DRUG AND ALCOHOL ABUSE IN THE ARMED SERVICES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON MANPOWER AND PERSONNEL

AND THE

SUBCOMMITTEE ON PREPAREDNESS

OF THE

COMMITTEE ON ARMED SERVICES UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

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DRUG AND ALCOHOL ABUSE IN THE ARMED SERVICES

TUESDAY, MAY 18, 1982

U.S. SENATE,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL
AND SUBCOMMITTEE ON PREPAREDNESS,
Washington, D.C.

The subcommittees met in open session at 10:09 a.m. in room 224, Russell Senate Office Building, Hon. Gordon J. Humphrey (chairman of the Subcommittee on Preparedness) presiding.

Present: Senators Humphrey, Jepsen, Exon.

Staff present: Anthony J. Principi, counsel; Paul C. Besozzi, minority counsel; Richard D. Finn, professional staff member; Kimberly A. Manning, staff assistant.

Also present: George Kohl, Emily Donovan, Nancy Wolicki, Meredith Nugent, assistants to Senator Humphrey; Jim Dykstra, assistant to Senator Cohen; Jon Etherton, assistant to Senator Jepsen; Paul Schreiber, assistant to Senator Denton; Gray Armistead, assistant to Senator Byrd; Greg Pallas, assistant to Senator Exon.

OPENING STATEMENT BY SENATOR GORDON J. HUMPHREY, PRESIDING

Senator HUMPHREY. Good morning.

I want to thank my colleague, Mr. Jepsen, for his interest in alcohol and drug abuse in the military and his assistance—as well as that of his staff—in making this hearing possible. I appreciate his efforts and welcome the opportunity to co-chair this hearing with him.

For my part, my interest flows from my chairmanship of the Subcommittee on Preparedness and, likewise, the chairmanship of the Subcommittee on Alcoholism and Drug Abuse of the Labor and Human Resources Committee.

Over the past several years, there have been numerous hearings on the problems of alcohol and drug abuse in the military. In addition, the media have instantaneously brought to our attention accidents and other incidents which have alerted the Congress and the American public to the fact that alcohol and drug abuse in the military may be causing serious problems for this Nation's military readiness.

Although in this field there are no clearcut answers, the armed services have instituted many programs designed to meet the challenges of military alcohol and drug abuse. The Chief of Naval Op-

erations recently produced videotapes shown to all Navy personnel leaving no uncertainty that the Navy is "getting tough" and will not tolerate drug abuse. The Marines have taken a very similar approach, while the Army and Air Force have consistently worked through their local commands to institute programing to address this growing national concern.

These subcommittees have not scheduled this hearing today to demand quick fixes or immediate solutions to this problem. As chairman of the Senate Subcommittee on Alcholism and Drug Abuse, I realize that the problems of alcohol and drug abuse are pervasive in our society—civil and military—and demand multifaceted approaches which continue even when the initial pressure is off. They demand innovative programs in education, research, training, law enforcement, treatment, rehabilitation, and information dissemination.

I will put my statement in the record.

[The opening statement of Senator Gordon J. Humphrey follows:]

PREPARED STATEMENT OF SENATOR GORDON J. HUMPHREY

I would like to thank my colleague Mr. Jepsen for his interest in alcohol and drug abuse in the military and his assistance, as well as that of his staff, in making this hearing possible. I appreciate his effort and welcome the opportunity to co-chair this hearing with him.

Over the past several years there have been numerous hearings on the problems of alcohol and drug abuse in the military. In addition, the media have instantaneously brought to our attention accidents and other incidents which have alerted the Congress and the American public to the fact that alcohol and drug abuse in the military may be causing serious problems for this nation's military readiness.

Although in this field there are no clearcut answers, the Armed Services have instituted many programs designed to meet the challenges of military alcohol and drug abuse. The Chief of Naval Operations recently produced videotapes shown to all Navy personnel leaving no uncertainty that the Navy is "getting tough" and will not tolerate drug abuse. The Marines have taken a very similar approach, while the Army and Air Force have consistently worked through their local commands to institute programming to address this growing national concern.

These subcommittees have not scheduled this hearing today to demand quick fixes or immediate solutions to this problem. As Chairman of the Senate Subcommittee on Alcoholism and Drug Abuse, I realize that the problems of alcohol and drug abuse are pervasive and demand multi-faceted approaches which continue even when the initial pressure is off. They demand innovative programs in education, research, training, law enforcement, treatment, rehabilitation and information dissemination. I look forward to working with the Department of Defense and the individual services to insure that the Congress does its part to guarantee that this long-term effort does not falter, and that administrative roadblocks to producing a military free of alcohol and drug abuse are removed.

Today, I would like to direct attention to the depth of the problem, programs being planned and implemented to address it, problems that have been revealed in this programming and the long-term outlook for the military.

My staff and I have made numerous inquiries to establish the impact that drug and alcohol abuse is having on our Nation's military preparedness. I am sure you will tell us today the impact of alcohol and drug abuse on preparedness is difficult to measure. However, I believe it is critical that it be evaluated. Of serious concern to me as Chairman of the Preparedness Subcommittee is the impact of alcohol and drug abuse on performance, on unit cohesion and on military life. Of equal importance is the enormous administrative cost in time, and personnel of this national tragedy. I hope in today's hearing we can look at these issues.

I applaud the efforts currently underway in the Army to extend the time of basic training and move divisions of men together from the time of their enlistment and recognize that similar programs exist in other branches of the service.

I hope that these efforts will build esprit de corps, make the most advantageous use of peer pressure and diminish alcohol and drug abuse as well as other problems currently faced by our troops. I am also looking forward to hearing about the Tank Crew Cohesion Study undertaken by Walter Reed Army Institute for Research to explore the impact of alcohol and drug abuse on the cohesion of tank crews.

Finally, I would like to indicate to my colleagues and the witnesses here today that although a great deal of attention has recently been devoted to drug abuse in the military, it is critical that the magnitude of the problem of alcohol abuse be recognized and dealt with. Alcohol abuse in our society, as well as in the military, has reached worrisome proportions. It is critical that the services take action to eliminate the perception that excessive alcohol consumption is a part of service life. I have been pleased to have the opportunity to review the plans of all branches of the service for the deglamorization of alcohol consumption and look forward to hearing more about those efforts at this hearing.

I would like to thank our witnesses for their efforts in this field, their appearances here today and their continuing cooperation in addressing this pressing national problem.

Senator HUMPHREY. Senator Jepsen?

Senator JEPSEN. On behalf of the members of the Manpower and Personnel Subcommittee I would like to welcome all of you before the subcommittees this morning and to express our gratitude for your efforts to combat an insidious problem—drug and alcohol abuse.

At the outset I wish to state as clearly and emphatically as I possibly can that I do not subscribe to the belief that the military is comprised of a large number of "addicts" as some would have us believe. That is not the reason for today's hearing. There can be no greater disservice to our men and women in uniform than to foster such a misconception. The leadership of our Armed Forces can take pride in their accomplishments in controlling a serious problem. I wish that our civilian society was one-half as successful as the military in combating drug abuse among our Nation's youth.

I do recognize, however, that alcohol and drug abuse—especially marihuana use—continues to be a problem that plagues all segments of our society. If permitted to grow unchecked it could have a significant, adverse impact on military readiness.

Therefore, it is essential that the problem be constantly attacked on many fronts through education to alter peer pressure and to advise our youth of the inherent dangers of drug and alcohol abuse; rehabilitation for those in need and, most importantly, swift identification and prosecution, both administrative and criminal, for those who use, possess, transfer or sell any proscribed drug. In my opinion the trafficking of drugs is the most heinous of crimes and should be dealt with accordingly.

Recently, I introduced S. 2521, the Military Justice Act of 1982. Among other things this bill would add a new punitive article to the Uniform Code of Military Justice which would expressly make punishable the trafficking, manufacture, possession or use of controlled substances. The bill further would provide a scheme of maximum punishment of up to 25 years confinement and hard labor for trafficking hard drugs, such as heroin. Later in this session our subcommittee will hold hearings on this important subject.

Today's hearing will provide the members with the opportunity to review the current situation, assess its impact on readiness and consider

the programs which are designed to address the problems today and in the years ahead.

I thank you, Mr. Chairman, and we can now proceed in any way you desire.

Senator HUMPHREY. Very well. I think it would be in order, Senator, to introduce the witnesses and thank them for coming.

I will introduce them. First is Dr. John F. Beary, Acting Assistant Secretary of Defense for Health Affairs, Dr. Beary?

Dr. John H. Johns, Deputy Assistant Secretary for Defense for Drug and Alcohol Abuse Prevention.

I apologize if I breach protocol in the order of introduction by proceeding as it is listed here: Maj. Gen. William R. Usher, Director of Personnel Plans, U.S. Air Force; Rear Adm. Paul J. Mulloy, U.S. Navy, Director of Human Resources Management Division, Office of the Chief of Naval Operations; Brig. Gen. John H. Mitchell, Director of Human Resources Development, Office of Deputy Chief of Staff for Personnel, Department of the Army, and Brig. Gen. Anthony Lukeman, U.S. Marine Corps, Director of Manpower Plans and Policy Division.

Good morning, and thank you again. Dr. Beary, may we have your statement and because of the number of witnesses, will you summarize it. This applies to all witnesses this morning. We will include your statements in full.

STATEMENT OF THE HON. JOHN F. BEARY III, ACTING ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS

Dr. BEARY. Senator Humphrey, Senator Jepsen, thank you for the opportunity to appear before your committee today.

I welcome this opportunity to discuss the current status of substance abuse in the Department of Defense. The interest of various congressional committees enhances awareness of the problem and has a positive impact on our efforts in this area.

The abuse of alcohol and other drugs is a significant problem in our Armed Forces, just as it is in our society. The attention given to drug abuse by the First Lady and the growing parent movement have helped to focus concern on this menace to health and military discipline.

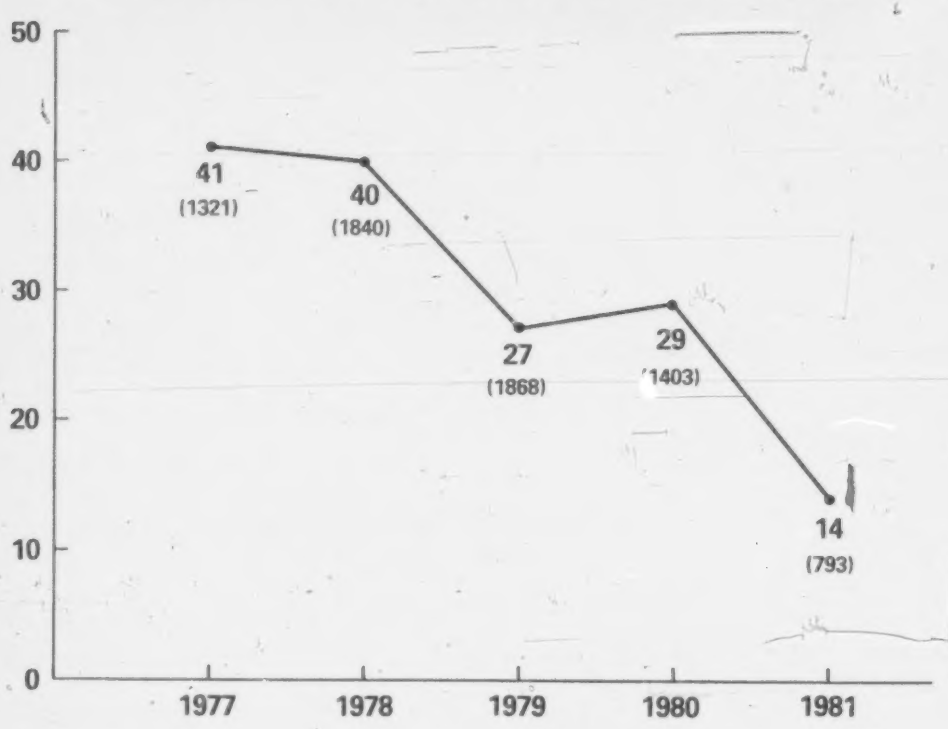
As the Acting Assistant Secretary of Defense for Health Affairs, I am charged with oversight of a broad range of medical programs, including the drug and alcohol abuse area. From this position I have had direct access to both Secretary Weinberger and Deputy Carlucci, and I can assure you that both are most supportive of our efforts regarding substance abuse in the Department of Defense.

A first and essential step in developing an intelligent policy toward substance abuse problems in the military is to define the nature of the problem accurately. I think as I go into this you will see what I mean.

It is inaccurate as well as a serious disservice to servicemembers—as Senator Jepsen mentioned—to foster the notion that the military has large numbers of addicts. The number of people with addiction problems is actually quite small. In fact, the use of opiates has steadily

decreased in the military and each year shows an improvement in this trend. We have a chart to illustrate this.

MILITARY PERSONNEL OPIATE USE (RATE PER/10,000 URINE TESTS)



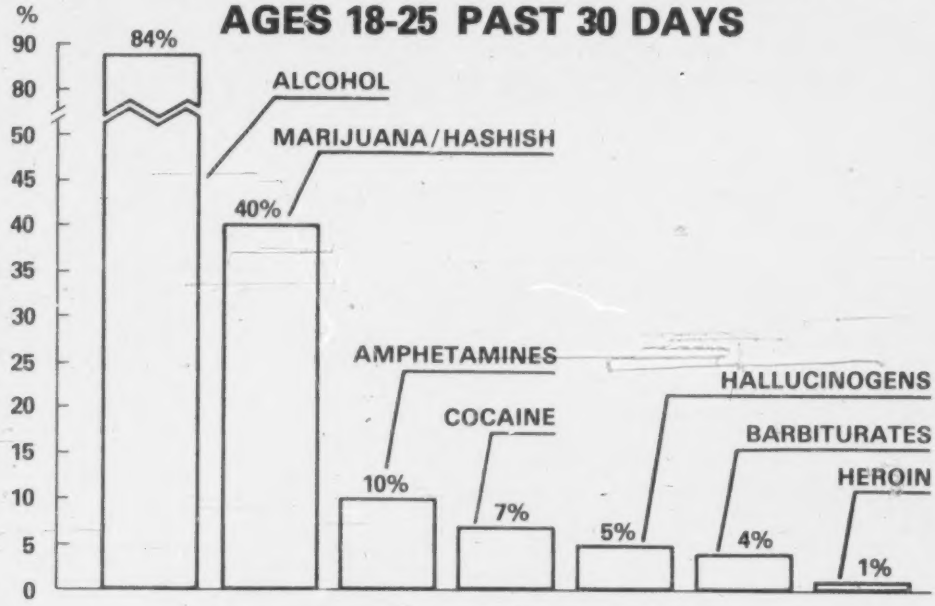
Early in the 1970's, during the Vietnam period, the opiate problem became pronounced. As you can see, in this period covering 1977 to 1981, by targeting appropriate resources to address the problem, we have seen steady improvement in this area and expect to see more as time goes on.

The fact is, addiction and severe behavior disorders, although present in some users, are not the major aspects of the military drug abuse problem. Alcohol and cannabis—or marihuana—are the drugs most often used, in that order. Chart No. 2 helps make that point.

The survey, first conducted in 1980, will be repeated in the autumn of this year. The current data is based on self-reporting methodology. We intend to utilize direct observation methodology in future studies, but this is the best data, available at this time.

This chart shows the prevalence of drugs that are being used. Clearly, our two major problems are with alcohol and marihauna. I will point out that, any use of these substances at all, even a beer with lunch would show up in this column.

DRUG USE AMONG MILITARY PERSONNEL AGES 18-25 PAST 30 DAYS



1980 WORLDWIDE DoD STUDY

Forty percent of the age 18 to 25 group reported using marihuana-hashish in the past 30 days. I draw your attention to that age group, 18 to 25, which comprise 63 percent of the force and is where the majority of our problem is. As you know, there are some troubles occasionally with officers and NCO's and so forth, but when you really look at where the most manpower is lost to DOD, the biggest expense to DOD and lost training time, medical costs, et cetera, it is in this young adult-late adolescent group.

As I said, in order to prescribe proper treatment you must first diagnose the problem. As I have taken pains to point out our problem is not addiction. The best words that one would use, to describe our problem is "conduct disorder." Conversations with several drug abuse experts, people on psychiatric faculties, have led to agreement with this terminology.

So, let us say we call it conduct disorder. What does that mean? If we are budgeted for about $140 million for all three services for the drug-alcohol program in fiscal year 1983, what mix of prevention and treatment are we going to use?

These people by and large are not drug dependent, that is, they are not daily users. Some of them, about 9 percent of that marihuana group, would be daily users, but most of them are not.

Senator JEPSEN. Doctor, excuse me, before we leave that chart—to get a perspective on it—the chart shows anyone, a person who is on leave or at home smokes some marihuana, that is included in that?

Dr. BEARY. That is correct—on duty and off duty is all reflected.

Senator JEPSEN. Do you have, or are you going to have, a chart later on that shows the use of it on board ship or in a specific duty on a more specific basis? Do you have a breakdown like that?

Dr. BEARY. We do not have a chart. I might just speak to that right now.

The self-reported, on-duty use of alcohol, DOD-wide, which would include a number of related problems such as coming to work late, and poor work performance, is about 30 percent.

Cannabis, self-reported impairment at work is about 20 percent. I will point out again; this is self-reported data. We are designing a study to actually take teams of physicians and psychologists on board ships, into military bases and find out in a random study exactly what the true numbers are by making direct observations, something that has not been done before. Hopefully, this time next year, we will have harder data for you on that matter.

As I said, once we have made this diagnosis of conduct disorder, the implication is to put more of your resources into prevention, with tough detection programs and a good legal program to punish those where it is indicated, discharge those where it is indicated, so forth and so on.

We must give consideration to what kinds of recreational opportunities are available for these people off duty. Young people are going to indulge in any number of activities. As we all know, "idle time is the devil's workshop," and all that.

Therefore, we must develop plans to provide structured activities for these individuals during off-duty hours. It is a complicated concept and Dr. Johns will elaborate on that in his testimony. The bottom line is that a day of counseling will not turn the problem around. That is why I want to stress the importance of prevention as opposed to treatment, particularly with this age group.

Many of the youths of our society are socialized into a drug-using culture. The use of cigarettes and alcohol has been glamorized through massive advertising efforts. During the last few years, the drug culture has been widely commercialized in our music, movies, magazines, and TV shows. The messages in society say, "do drugs."

This is not the case in the military. We are very clear on this matter and have purposely instituted an education program which specifically informs recruits of the disciplinary, career, and health consequences of alcohol abuse or illegal drug use.

We see encouraging signs that parent groups are successfully attacking the "do drug" messages in our society. As they become more active, our education role can change to one of reinforcement. Unfortunately, today we are often performing major surgery on young people who could have been helped by a little first aid a few years earlier.

As this chart indicates, our two major substances of concern are alcohol and cannabis. I will just briefly touch on our approach to each.

We are getting very tough on alcohol abuse to show we do not have

a tolerant attitude toward that drug. My staff is preparing a drunk-driving initiative to assess what is the leading cause of death of young people under age 40; auto accidents. Fifty percent of those accidents are attributed to alcohol involvement.

We intend to increase the fear of apprehension for drunken driving to such a level that people will walk or take a taxi rather than risk a DWI arrest.

I have a personal interest in the drunk driving issue. I worked in emergency rooms as part of my medical training and practice, and there just really is not anything that breaks your heart more than to walk out into a waiting room and have to tell the parents that their child has been wiped out by a drunk driver. That happens every hour as we sit here talking.

The recidivism of drunk driving is appalling. I have spoken with General Wickham about the program he had at Fort Campbell in Kentucky. By verifying the arrest records in surrounding counties and those on post, as well as the posts where people had been before being assigned to his command, he found that the same individuals would come back a fourth and fifth time. He decided that it was time to make an intervention. When he did, he drove his deaths down from 55 to 22 over a comparable reporting period.

We do not just have to throw up our hands and say, "Nothing can be done, that is the way it is." There are several things we can do. One aspect we are considering is the effectiveness of peer pressure. One interesting idea that a commander might use is a car bumper sticker that says, "convicted of drunk driving," and put it on the front and back of the convicted individual's car for 30 days. The point of doing that is twofold. One is to allow other drivers to avoid them on the highway and the other one is to have heat put on them by their peers, by their family, and by their commanders, which is a very embarrassing situation. Hopefully, that will get the message across. They are not going to have to wear the "scarlet letter" for the rest of their lives but for 30 days or so, and we would hope that it will do some good. We think that this is a way to get started. Dr. Johns will go into more detail about our tough actions against cannabis users but basically we have two things we did not have this time last year.

One is a legal tool. Mr. Carlucci signed a memorandum in late December, giving the services power to use urinalysis results in court cases. We also have a urinalysis testing capability that we did not have this time last year. Cannabis is a very complicated chemical with many different subclasses, and it took longer to develop a reliable analysis than it did for some simpler compounds like barbiturates.

My final comments deal with research efforts. I mentioned we are going to repeat this study in October of this year. We will do it every 2 years thereafter, with the enhancements I mentioned we hope to get some direct observations of the problem. We are getting very good cooperation from the services in helping us with this matter.

Another major point—I am sure one that has concerned you, Senator Humphrey—is that data on the effectiveness of rehabilitation is very anecdotal. Some studies suggest we get the same outcome from a 1-day counseling session as we do from 30 days in the hospital. Obviously, the difference of costs of these two modalities is significant.

In response to this we are putting together a research proposal to try to resolve that issue, and we appreciate your interest and support. We hope to apply more modern scientific methods in our treatment programs, and reduce our reliance on anecdotal information.

In my own practice I have observed that drug abuse is almost nonexistent among practicing Mormon teenagers. The Mormon faith puts a high value on wholesome family life. Investigations are being designed to study these observations and to assess the relative contributions of strong family life and religion. Perhaps observations on the mental health of religious groups will be analogous to studies of the lifestyle of Seventh Day Adventists which showed lower cancer rates in this population. We are going to try to look for some clues within these groups.

My comments today have emphasized data collection and analysis. I intend that our efforts be of sufficient quality to see where we are, where we are going, and to change our course in a timely fashion if necessary. Our policies will be based on hard data, not on anecdotal information.

As you mentioned, like many health problems, substance abuse is complex and will not be solved overnight. However, we have made a vigorous start. I will conclude by assuring you that this program has and will continue to have my full personal support and interest.

Dr. Johns will discuss the details of our program in his statement.

Senator HUMPHREY. Very well. Thank you, Dr. Beary.

[The prepared statement of Dr. John F. Beary follows:]

PREPARED STATEMENT OF JOHN F. BEARY III, M.D., ACTING ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

Mr. Chairman, thank you for the invitation to appear before this Committee. I welcome the opportunity this hearing provides to discuss the current status of substance abuse in the Department of Defense. The interest of various Congressional Committees in regard to drug and alcohol abuse enhances our awareness of the problem and has a positive impact on our efforts in this area. The abuse of alcohol and other drugs is a significant problem in our Armed Forces, just as it is in our society. The attention given to drug abuse by The First Lady and the growing parent movement have also helped to focus concern on this menace to health and military discipline.

As the Acting Assistant Secretary of Defense for Health Affairs, I am charged with oversight of a broad range of programs including medical readiness, CHAMPUS, preventive medicine, alcohol and drug abuse, and a number of others. From this position, I have direct access to both the Secretary of Defense and his Deputy and I can assure you that both are most supportive of our efforts regarding substance abuse in the DoD.

A first, and essential, step in developing an intelligent policy toward drug and alcohol abuse is to define the nature of the problem accurately.

It is inaccurate as well as a serious disservice to Service members to foster the notion that the military has large numbers of "addicts." The number of "addicts" in the military is very small. In fact, the use of drugs such as opiates has steadily decreased in the military and is negligible. (Chart No. 1—Opiate Trend.) (See chart 1, p. 5.) Our surveys show this, our medical reports show this and Congressional studies show this. However, we consider any use of illegal drugs to be serious and we will continue to have a tough policy to reduce such use even further.

The fact is that addiction and severe behavior disorders, although present in some users, are not major aspects of the military problem. Alcohol and cannabis are the drugs most often abused, in that order. (Chart No. 2—Alcohol/Marijuana Prevalence.) (See chart 2, p. 6.) Further, single males under age 25 are the population most at risk.

Many of the youth of our society are socialized into a drug-using culture. The use of cigarettes and alcohol has been glamorized through massive advertising

efforts. During the past few years, the drug culture has been widely commercialized in our music, movies, magazines and TV shows. The messages in society say "do drugs." This is not the case in the military. We are very clear on this matter and have purposely instituted an education program which specifically informs recruits of the disciplinary, career, and health consequences of alcohol abuse or illegal drug use. We see encouraging signs that parent groups are successfully attacking the "do drug" messages in society. As they become even more active and successful, our education role can change to one of reinforcement. Unfortunately, today we are often performing major surgery on young people who could have been helped by a little first aid a few years earlier.

We plan to change the attitudes toward alcohol and cannabis by several means. First, we intend to get tough on alcohol abuse to show we do not have a tolerant attitude toward that drug. My staff is preparing a drunk-driving initiative to address the leading cause of death in people under age 40. We intend to increase the fear of apprehension for drunken driving to such a level that people will walk or take a taxi rather than risk a DWI arrest.

Second, our tough actions against cannabis users (based on our new laboratory and legal tools) will be accompanied by a long term systematic program that involves effective education and development of cohesive military communities and organizations that have norms and values that discourage drug use. If we expect to channel peer pressure against cannabis use (and this is essential in controlling it), we must change the current attitudes. This will be a long term process. Although we have scientific evidence on the danger of cannabis use, we cannot assume those facts will have an immediate impact on behavior any more than did the scientific evidence on cigarettes.

In 1980, the Department conducted a world-wide survey which provided my office with detailed information concerning the prevalence and consequences of drug abuse in the military. This has proven to be the cornerstone of our assessment system and will be repeated every two years to provide trend data as well as to examine the nature and extent of our current problem. We are also conducting similar surveys which will focus on DOD civilian employees and our DOD high school students overseas. I went to place our resources where they are most appropriate. Therefore, I am working very hard to set up an effective drug information reporting system.

There are two areas where more research is needed. We are designing a study that will provide scientific information on the degree of work impairment in military members with a positive urinalysis. It is essential that we understand more clearly the impact of substance abuse on performance. The design for this project will be completed soon.

The second effort will determine the effectiveness of different types of rehabilitation. The medical literature contains little of value on this subject. We need to know the optimum treatment modality for various degrees of drug use and the appropriate length of treatment. Currently the Military Services offer a variety of rehabilitation programs, using approaches that vary in length from one day to eight weeks. If we can determine what works best for most people, we will then be able to adjust our policy based on scientific evidence and use our limited resources in the most effective manner.

There have been anecdotal observations that drug abuse is almost nonexistent among Mormon teenagers. The Mormon faith puts a high value on wholesome family life. Investigations are being designed to study these observations and to assess the relative contributions of strong family life and religiosity. Perhaps observations of the mental health of religious groups will be analogous to studies of the lifestyle of Seventh Day Adventists, which demonstrated lower cancer rates in this population.

My comments today have emphasized data collection and analysis. I intend that our efforts be of sufficient quality to see where we are, where we are going and to change our course in a timely fashion if necessary. Our policies will be based on hard data, not on anecdotal information.

Like many health problems, substance abuse is complex and cannot be solved overnight. However, we have made a start. I am convinced that continued high level support for our effort coupled with systematic, vigorous leadership will continue to yield progress in reducing the impact of alcohol and drug abuse on the effectiveness of our Armed Forces. I assure you that this program has, and will continue to have, my full personal support and interest. Dr. Johns will discuss the details of our program in his statement.

Senator HUMPHREY. Before we go on with Dr. Johns I want to welcome Senator Exon. Good morning, Senator Exon, do you want to make an opening statement?

Senator EXON. No, I have nothing to say. I am very much interested in this proposition and I will be here to listen and ask some questions at the appropriate time. Thank you.

Senator HUMPHREY. Fine. The way we are going to proceed is, we will take the statement of each of the witnesses and then we will go to questions. May I stress again the need to summarize the statements.

STATEMENT DR. JOHN H. JOHNS, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR DRUG AND ALCOHOL ABUSE PREVENTION

Dr. JOHNS. I believe it is useful to look at our current effort in the context of the historical way we have approached this problem.

In the early 1970's, the Department of Defense made the first big effort in coping with drug abuse and, as you are all well aware, it dealt almost exclusively with opiates, specifically heroin, in Vietnam. There is no question that it was of epidemic proportions.

We defined our drug problem then as basically an addiction problem. We put a lot of resources in the treatment, long treatment periods, rehabilitation, detoxification. We did that through 1974 and then went into a rather, maybe we can call it "lackadaisical" approach in the Department of Defense. I think that was due to two things: One, the Vietnam war wound down and second, there was a court decision which prohibited us from using urinalysis results for disciplinary action.

So, we went into a period where we did not take very aggressive action. We were stimulated in 1978 by certain congressional committees to get with it again. We did, and we focused on the so-called hard drugs.

You saw the results of our drive on the use of the opiates. Methaqualone, in Europe, went from 110 positives for 10,000 urine samples in 1978 down to 10 in 1981. In a 3-year period we decreased the use of methaqualone by 90 percent. Amphetamines were reduced by about 80 percent, but now it is on the upward trend again.

Those gains made since 1978 were done with severe handicaps. There were court decisions by the Court of Military Appeals that would not allow us to do morale and welfare inspections: would not allow us to use evidence when we accumulated it; would not allow us to take action against people who did things off base, off duty: would not allow us to use urinalysis test results. Fortunately, all of those decisions have been overturned and now we believe that we have the necessary legal tools to be more aggressive.

That was reflected in the December 28, 1981, memo from Mr. Carlucci to the services. As a result of that, we have put teeth in our program. Each of the services that you will hear describe their program are going about it in a different way because they have unique requirements, but we believe that all of them are going about it in a very aggressive manner. And as long as they are aggressive about it we will tolerate differences because we do not have the solutions in the Office of the Secretary of Defense; we do not try to im-

pose our particular brand of policy on them if they show us that they are sincere, and I believe they are.

As Dr. Beary mentioned, I think the key to coping with this problem is an accurate definition of the problem. It is clearly not what we saw in the early 1970's and, as Senator Jepsen mentioned about the perception of the American people, some of the letters that I get from genuinely concerned parents and citizens are distorted. Their perceptions see junkies. They see on the news, TV programs, sailors with track marks up their arms. The next cut shows 48 percent admitted the use of drugs during the last year. They connect those two and they think half of our sailors, soldiers, marines, and airmen are junkies. That is simply not the case.

The problem of drug abuse in the military is closely associated with the rites of passage of young adolescents who feel that they have to use some substance. It used to be cigarettes and alcohol, and now we have added marihuana to it. It just seems to be a stubborn part of their rites of passage to use drugs to show that they are "cool."

Now, very few of them retain this after they are 25 years of age. They become more responsible. A few of them get hooked, psychologically addicted to marihuana and are not able to shake it. But the basic part of the problem is that it is part of the youth culture.

Now, that is worth emphasizing because if you are going to approach that in the military you have to approach it from a standpoint of how you change the youth culture—the norms and values. And that means peer pressure. There are strict limitations as to how far you can go with punitive measures in changing peer pressure. It just does not work that way with my children, your children, or youth in general.

So, our program has been basically oriented toward keeping pressure on the so-called hard drugs, the opiates, amphetamines, barbituates and those others that really bother us. And I might say, cocaine and amphetamines now are on the upswing in the society, so we have to be very careful about that. We are going to keep pressure on these and I believe with the ability now to use urinalysis results for punitive measures, we can reduce the use of drugs.

But we are going to focus especially on alcohol and cannabis. Now, by all measures alcohol is our biggest problem. As we have recently put the pressure on cannabis or marihuana, as you might expect, it is like pushing down on a balloon—alcohol abuse has gone up. So, we are going to have to push both of those at the same time.

We are shifting from treatment and rehabilitation, particularly residential treatment, where we put people for 4 to 6 weeks, and we are focusing on prevention. As you know, we can use sniff dogs and fluoroscopes for checking the mails, as soon as the agreement with the Postal Service is finalized, which we expect will occur on or about July 1, 1982.

So, we will put on pressure and we are going to have tough penalties for those who continue to use illicit drugs. We will give them help where needed, but when they do not want it, we are going to get rid of them.

Now, let me talk about the steps that Dr. Beary mentioned for creating cohesive units. I know at least those of you on Mr. Jepsen's subcommittee have heard Dr. Charles Moskos talk about his belief

that the military must be a way of life, that is, it has to be more than just a job.

Well, many of the things we did over the years contributed to making the military more like a job. That is being reversed in the military and there is more and more attention being paid to making it sort of a community-type thing where people have a sense of belonging and a sense of commitment to the norms and values of the military.

I believe if we go about that systematically in the barracks, off-duty recreation time, getting good, concerned leadership so that you do more than bureaucratically manage people and give them the personal concern of a leader which has been the traditional emphasis in the value of leadership in the military, we will improve cohesion.

We believe that if we do that and do it sincerely and conscientiously, we will see some turn-around in this attitude in the military. We think we will get some peer pressure among the peers and cope with drug and alcohol abuse. That is a summary of my statement, Mr. Chairman. Thank you.

[The prepared statement of Dr. John H. Johns follows:]

PREPARED STATEMENT OF DR. JOHN H. JOHNS, DEPUTY ASSISTANT SECRETARY OF DEFENSE (DRUG AND ALCOHOL ABUSE PREVENTION)

Mr. Chairman, members of the Subcommittee. I am pleased to have the opportunity to appear before you to provide information on drug and alcohol abuse in the Department of Defense. I agree with Dr. Beary that the interest various Congressional Committees have shown in this important area has been constructive in its overall impact on our efforts to combat drug and alcohol abuse. We are committed to a cooperative relationship with Congress and pledge to be candid and forthcoming in our testimony.

Over the years, the Department of Defense has been criticized by some for not doing enough to solve the problem of drug and alcohol abuse. Some of that criticism has been justified, some has not. Part of this is our own making. A review of our past testimony will show that it has often been characterized by a list of "initiatives" that promises to have dramatic results in reducing drug and alcohol abuse. In some instances, these lists appear to be designed more for their short-term persuasive appeal than for their long term commitment to solve the problem. As a result, we have created a feeling among some that the Department of Defense promises, but does not deliver. I'm not sure we can counter that perception completely, but we intend to try.

The drug and alcohol abuse problem is a complex one. There are a number of views about how best to deal with it. Some of these views are linked to deep seated emotions that sometimes cloud rational discourse. We have a wide diversity of views within Congress, within the scientific community, within society and within the Department of Defense. Members of my own staff often express differences of opinion. It is my job to examine the problem, evaluate the various alternatives suggested and make policy recommendations to the Secretary of Defense.

RECENT EFFORTS

At the beginning of the recent Congressional interest in the military drug and alcohol abuse problem, around 1977–78, we focused our attention on opiates, barbiturates, amphetamines and similar drugs, especially what was perceived as an alarming increase in heroin use among our military forces in Germany.

A look at the data on drug use in the United States Army, Europe (USAREUR) will show that we had a large measure of success in our attack on opiates, amphetamines and methaqualone. Data at Enclosure 1 show clearly that such drug abuse has decreased dramatically since 1978. Only cannabis and alcohol remain at a persistently high level. I will discuss our efforts to combat the effects of these two drugs later in my testimony.

The significant progress we have made in our war on drug abuse was accomplished under some severe constaints. Court decisions during the 70's severely

hampered our efforts by denying the use of urine test results for disciplinary actions. Forms of search and seizure during inspections were hampered by court decisions as well. Postal Service regulations requiring search warrants issued by Federal judges or magistrates also provided problems since there are no judges or magistrates residing on ships or overseas. Fortunately, the court decisions have been reversed and a tentative agreement with the Postal Service has been reached which will provide the Department more latitude in dealing with the overall drug abuse problem.

While we have made significant progress in the reduction of abuse of opiates and similar drugs, we have made only limited progress in our battle with alcohol abuse, except in the treatment of alcoholism. We have some of the best rehabilitation centers in the world and we are expanding them. This aspect of our program is not only humane, but it is cost effective as well. Several studies have shown a high return on investment in terms of retention of skilled personnel. From all data available, whether it be medical data, disciplinary actions, survey data or command judgment, alcohol abuse is by far the most serious of all drug abuse types. Since it is legal for adults when it has no adverse behavioral consequences and is consumed off-duty, we are limited in the disciplinary measures which can be applied.

We have had extensive "deglamorization" drives. Some commanders have prohibited the sale or consumption of alcohol during "normal duty hours" and we require all persons who abuse alcohol to go through a formal "awareness" program. In spite of these measures, we have been frustrated in reducing alcohol abuse and alcoholism. As I will discuss later, we are continuing to look for ways to be more effective in dealing with this particular form of drug abuse, with special attention being paid to tough penalties for driving while intoxicated.

NATURE OF THE PROBLEM

In his testimony, Dr. Beary discussed the importance of defining the nature of the problem accurately. We believe that our 1980 military survey did precisely that. It gave us a realistic picture of the problem and provided us with sound information with which we are able to make policy decisions.

Studies consistently show that most of the drug and alcohol abuse, in civilian society and in the military, is found in the 18–25 year age group. Since 63 percent of the military force is in this age group, our population is "high risk." Drug and alcohol use is also closely correlated with being single, male and lower education achievement. Nationwide surveys also show that after leaving high school, the incidence of drug use increases for those who leave home and live with other singles, as they do in the military.

Our survey results clearly indicate that addiction and severe behavior disorders, although present in some users, are not major aspects of the military problem. Alcohol and cannabis (marijuana being the most common form) are the drugs most often abused, in that order. The use of these substances is widespread among the 18–25 year group and is closely associated with other behavior characteristic of the transition from adolescent to mature adult behavior. As with behavior that leads to high auto insurance rates for this group, drug and alcohol abuse drops sharply around the age of 25. While some drug and alcohol abuse persists beyond the age of 25, the bulk of the problem is in the 18–25 age group and we must understand the nature of that behavior if we are to make intelligent policy.

To associate the widespread use of alcohol and cannabis with behavior of adolescents transitioning to mature adult behavior does not minimize the adverse consequences of the behavior any more than attributing deaths from drunk driving of a 17-year-old to immaturity. The tragedy is the same. Coping with the problem, however, requires an understanding of the youth culture.

As the 1981 High School Seniors Survey indicates (Enclosure 2), the youth of this society are socialized into a drug using culture. The use of cigarettes and alcohol has been glamorized through massive advertising efforts. Adult users provide role models for youth. Use of these substances has been seen as a "rite of passage" to adulthood. Only recently have anti-smoking campaigns succeeded in turning the tide against cigarette smoking. Almost concurrently with this success in reducing cigarette smoking, the use of cannabis has become part of the rite of passage, giving us two psychoactive drugs with which to deal.

IMPACT ON READINESS

Our principal concern regarding the drug and alcohol abuse problem is its impact on readiness. This is a particularly difficult issue because of our inability to measure this aspect of the problem with precision. We do have some data, however, and we believe it provides a reasonably accurate approximation of the impact on readiness. For example, our 1980 survey attempted to estimate the effect of drug and alcohol abuse by asking respondents to report how frequently they had been impaired on duty and the kind of impairment. Clearly there are too many people who go on duty under the influence of alcohol and marijuana and too many who suffer from some form of job impairment because of their use of alcohol or other drugs.

In the absence of precise data on the impact on readiness from drug and alcohol abuse, we must rely heavily on the judgment of our front-line leaders and the "proof of the pudding," actual unit performance. Individual and unit performance are, of course, the result of a large number of factors and it is difficult, if not impossible, to isolate a specific factor such as drug abuse. There have been heated arguments, for example, over military performance as a function of educational level, mental level, etc. We know that educational level is related in general to motivation and that can be expected to influence performance. But, educational level is also related to drug and alcohol use, so how does one know if a lackadaisical person is that way because of the use of drugs or because of basic personality?

As a former career officer myself, I found it difficult to estimate "how much" any one factor influences unit performance. As I talk to commanders of all ranks now in my current job, I find the same problem. It is human nature to look at one's own unit through rose-tinted glasses and see it in the best light. Congressional investigators repeatedly question the credibility of commander's assessments because of that tendency. And yet, when a commander is challenged on his assessment, he will often offer an invitation for the investigator to evaluate the performance of the unit. Several years ago, when I implied that a commander was using rose-colored glasses to estimate his drug problem, he invited me to come out the next morning at 6 a.m. to run four miles with his unit and watch it perform the complex operations it had scheduled. Their performance was impressive.

Most of our commanders recognize they have a serious problem with drugs and alcohol, especially with alcohol. But they consistently maintain that, even though they are impaired, their overall unit readiness is as high as it has ever been. The commanders of U.S. Air Forces, Europe recently showed me that, by all measures, that command had the best performance record in its history. The other Services have similar examples. We believe it is a serious mistake, and an injustice to the U.S. military's men and women, to cast doubt on our overall readiness. Common sense tells us that drug and alcohol abuse degrades readiness to some degree, but we really do not know how much.

DISCIPLINE AND ILLICIT DRUG USE

Any use of illicit drugs is classified as abuse in the military regardless of the behavioral consequences. Disregard for laws, rules and regulations undermines good order and discipline in the military. Therefore, we are concerned with the use of illicit drugs regardless of the behavioral impairment it may cause. Illicit drug use also brings our people into an association with criminal elements. On the other hand, laws which are not widely supported by peer pressure are difficult to enforce. Experience has shown that such undesirable behavior can never be completely eliminated by official punitive measures and can even create a backlash if too harsh.

There is strong evidence that, in the view of youth, alcohol and drug abuse, particularly the occasional use of cannabis, is viewed in a similar manner. If it does not impair duty performance, many youth argue, it is a personal affair. Unfortunately, many of the alcohol and drug users do not appreciate that their behavior is impaired. This is especially true of marijuana users, who tend to view the "high" as the only effect of that drug. Since the "high" lasts only a short while, they do not consider it bad if not used on duty. Ignored is the strong evidence that impairment persists, often in very subtle but dangerous ways. We have to change these attitudes.

CURRENT POLICY AND FUTURE PLANS

Earlier in my testimony, I made reference to recent court decisions that have given us some powerful tools to strengthen our war on drugs. Of particular importance is a decision that now allows us to use urine test results for a number of distinct purposes. First, they may be used to identify personnel for referral to counseling, treatment and rehabilitation programs. Second, they may be used as evidence in actions under the Uniform Code of Military Justice when constitutional safeguards are followed. Urinalysis results can also be used as a basis for characterizing discharges as less than honorable. We believe this authority, which we announced to the Services on December 28, 1981, will result in significant progress in reducing drug abuse.

Concurrent with the court decisions, we had a technological breakthrough in the identification of cannabis use by urinalysis. It is a new technology, however, and we want to insure that we have the wrinkles ironed out before issuing definitive long-term policy guidance on its use. As we have done with each of the techniques for identifying specific substances, we conducted a field test. The field test was conducted for both the laboratory urinalysis procedures and the portable urinalysis systems. The tests were started on October 1, 1981 and continued through March 31, 1982 for the the laboratory process and will continue through September 1982 for the portable system. After the Military Departments have submitted their evaluations of the tests, we will issue further policy guidance on the use of urine testing for cannabis use.

We have an aggressive research plan designed to give us a better understanding of the problem of drug and alcohol abuse and to evaluate programs. A high priority project is designed to get a measure of the actual impairment of behavior associated with drug and alcohol use. The study design calls for a team of medical personnel to make surprise visits to various military units. Urine tests, breathalyzers and blood tests will be used to identify those who have used alcohol and/or drugs. These individuals will be interviewed, given psychomotor tests and other measures of impairment and compared with a control sample. We expect to start data collection in a few months, using DoD personnel to conduct the study. We are working with NIDA on this study.

We also plan to conduct a thorough scientific evaluation of our treatment and rehabilitation programs. This will be a contract study to begin in fiscal year 1983 if funds are available. The study will be designed to compare the efficacy of various modes of treatment, e.g., what is the relative effectiveness of 8 hours versus 36 hours of education for persons identified as nondependent drug users? Is a six-week rehabilitation program for alcoholics more effective than a four-week program?; etc.

Another study which we are working on will investigate the anecdotal observations that drug abuse is almost non-existent among certain sub-cultures in U.S. society, e.g., among Mormon teenagers. We hope to learn some principles that can be applied in the military.

As previously noted, punitive measures alone cannot solve the alcohol and drug abuse problem. As with any form of widespread misconduct, the sanctions to modify that conduct must come from within individuals themselves and from peers in their day-to-day living. The values and norms of military communities and organizations must reflect a positive demand for mental and physical well-being and high unit performance.

Achieving such an organizational climate has always been a goal of military commanders. Some have achieved it in local areas better than have others. The pervasiveness of drug and alcohol abuse, however, suggests we need to make a more systematic effort throughout the military. Each of the Services now has underway various activities designed to develop pride and professionalism, better discipline and stronger cohesion in small units.

Creating cohesion in military units requires much more than "just good leadership," however important that factor is. Many historical trends during the past generation have had a negative impact on unit cohesion. We don't intend to try to turn the clock back; rather, we will look for innovative and systematic ways to overcome the adverse impact on cohesion. Among the steps we want to take are:

Improve the quality of non-commissioned officer leadership. Recent improvements in compensation will help retain seasoned sergeants and petty officers who leave the Service. It is essential that we have top-quality NCOs to serve as a role models for our young people who are developing into adulthood.

Create wholesome barracks living for junior enlisted personnel. Some of the barracks which we require our junior people to live in are sub-standard, especially those in Germany.

Structuring of off-duty time for the single person living in barracks. In initial-entry training, where off-duty time is highly structured and where life is spartan and physically demanding, drug abuse is insignificant. In the era of the All Volunteer Force, such mandatory structurng of off-duty time is not practical. However, we want to look for ways to attract voluntary participation in organized activities that promote mental and physical well being and unit cohesion.

Initial-entry training must be tough, mentally and physically, with more emphasis on the inculcation of values and attitudes compatible with a disciplined, drug-free military community.

Finally, I would like to address our efforts to provide adequate alcohol and drug abuse programs for our civilian employees who account for about one-third of our total strength. We are not fully satisfied with the overall emphasis provided to our civilian program even though our results during the past four or five years compare favorably with other Federal Agencies.

Allocation of resources is the most significant problem retarding our progress. In many cases, the civilian program coordinator has responsibilities for a large number of unrelated programs with virtually no time to manage the alcohol and drug program. We have found that in those Services and Agencies where the civilian program coordinator is a full-time position or at least a major duty, the program is effective. In those instances where these responsibilities are but one of many assigned tasks, the program is ineffective.

We will continue our efforts to convince commanders and managers that drug and alcohol programs for civilian employees are not only necessary, but, when implemented properly, can significantly increase the overall job performance of their staff.

My office was instrumental in establishing the Pentagon Employee Referral Service (PERS) which began operating in July of 1981. The PERS was created to assist supervisors and employees in achieving optimal job performance through resolution of presenting problems. Services include problem evaluation, referral to appropriate community treatment resources, monitoring employee progress, consultation with supervisors and appropriate education classes. As of 31 March 1982, after only nine months of operation, we have had 300 referrals. This program, which has received nationwide acclaim, is not only helping many civilian employees with problems, it is also a symbol of the Secretary's support for DoD civilian alcohol and drug abuse programs.

Additionally, we are in the process of conducting a drug and alcohol abuse prevalence survey of DoD civilians similar to the one done for the military in 1980. The information gained from this survey will further convince commanders and managers that additional resources and efforts are needed.

The Department of Defense, as the Federal Government's largest employer, must fulfill its obligations to employees and management by operating a realistic and workable Federal alcohol and drug program. The opportunity to enhance the effectiveness of our civilian workforce is great. We are taking advantage of that opportunity now and plan to make an acceptable program better.

The Department of Defense has made a sincere and consistent effort during the past four years to cope with the drug and alcohol abuse problem. We have made considerable progress in reducing the abuse of most drugs. The abuse of alcohol and cannabis products (mostly marijuana) has remained about the same.

Our effort has been hampered by two significant obstacles: court decisions that limited the action we could take based on urinalysis results and our inability to detect cannabis use through urinalysis. Both these obstacles have now been removed.

With legal authority to use urinalysis results for punitive actions and the ability to detect cannabis by urinalysis, DoD has announced policy guidance that gives commanders the tools to take a tough stance on drug abuse.

We plan an equally tough approach to school abuse, especially when there are adverse behavioral consequences such as driving while intoxicated.

Coping with cannabis and alcohol abuse will be difficult because of the nature of the problem with these drugs. Abuse is largely associated with the transition from adolescence to mature adulthood. Both substances are viewed in a similar

vein by young people. Our tough punitive measures must be accompanied by a long-term, systematic effort to change attitudes toward these two substances.

We have made significant progress in improving programs for our civilian employees. The results of this year's survey will provide us with scientific data on which to base some program refinements.

We do not expect all of you to agree with everything we do, nor for that matter do we have unanimity within the Department of Defense. I believe we can all agree, however, on our ultimate objective, which we have had for several years—to have a Department free of drug and alcohol abuse and thus maintain the state of readiness essential to preserve our national security.

I would be pleased to answer any question you may have.

ENCLOSURE 1.—LABORATORY POSITIVES/10,000 TESTS IN U.S. ARMY EUROPE

Drugs	1978	1981
Opiates	360	25
Amphetamines	100	50
Methaqualone	110	10

Source: Medical perspective for Army drug and alcohol abuse prevention program—4th quarter, calendar year 1981, USAREUR briefing.

ENCLOSURE 2

Subject: High School Seniors Survey—1981.

The following information is extracted from the University of Michigan's Institute for Social Research recently released report, "Student Drug Use in America 1975–1981."

Two-thirds (66 percent) of all high school seniors in the 1981 survey reported illicit drug use at some time in their lives. This reflects a gradual decrease of about 1 percent per year since 1978 due to changes in marijuana use. A substantial proportion of these seniors have only used marijuana (23 percent).

Marijuana is by far the most widely used illicit drug with 60 percent of the seniors reporting lifetime use, 46 percent annual use, and 32 percent current use in past month. Since 1978 there has been a sharp downward trend in daily marijuana use from 11 percent to 7 percent. Annual use has dropped during this period from 50 percent to 46 percent but lifetime use has remained constant at 59 percent.

A substantial majority of seniors perceive regular use of any illicit drug other than marijuana as entailing "great risk" of harm for the user. About 58 percent perceive regular marijuana use as "great risk" in contrast to 63 percent who feel this way about cigarettes. Very few think there is much risk in using marijuana experimentally (1[illegible] percent) or even occasionally (19 percent). However, there is a substantial increase since 1978 in the percentage of seniors who view the regular use of marijuana as harmful (43 percent in 1978 versus 59 percent in 1981).

The most widely used class of other illicit drugs is stimulants (32 percent lifetime prevalence, 26 percent past year and 16 percent past month).

The use of alcohol and cigarettes remains more widespread than the use of any of the illicit drugs.

Nearly all students have tried alcohol (93 percent lifetime, 87 percent past year, 71 percent past month). While daily alcohol use is 6 percent, a greater proportion report occasional heavy drinking (41 percent state that on at least one occasion during the two weeks prior to the 1981 survey, they had five or more drinks in a row). There has essentially been no change in lifetime, annual, current (monthly) and daily alcohol consumption statistics since 1975. Very few seniors (22 percent) associate much risk with having one or two drinks a day whereas 36 percent consider five or more drinks on a weekend to be harmful and 65 percent believe this for heavy daily consumption.

Senator HUMPHREY. Thank you, Dr. Johns.

General Usher, can you restrict yourself to 5 minutes? I want to save the bulk of the time here for questions and answers. I think that is the most useful.

STATEMENT OF MAJ. GEN. WILLIAM R. USHER, DIRECTOR OF PERSONNEL PLANS, U.S. AIR FORCE

General USHER. Mr. Chairman, I think it will take just about 5 minutes.

I appreciate the opportunity to be here this morning to discuss the efforts of the Air Force to combat the effects of drug abuse, and I include alcohol abuse.

I would like to first emphasize that we established a comprehensive and tough abuse control program for both alcohol and illicit drugs more than 10 years ago in the Air Force and have continually refined and tightened these programs over time.

However, throughout that period the central theme has not changed. We consider drug and alcohol abuse to be incompatible with the Air Force's mission. It is not tolerated and we hold commanders—and this is the key—at all echelons responsible for preventing it. Our basic objectives are: Prevention of abuse, discipline and rehabilitation for those who need it; and the separation of those who cannot or will not rehabilitate.

Our drive to reduce drug abuse is reflected in a special project now under way to expand testing of portable urinalysis equipment to both detect and deter marihuana use. Over the next several months we will conduct no-notice urine sweeps at Air Force bases in the United States. Through this project, we will assess the portable devices, measure drug abuse prevalence and clearly demonstrate to Air Force personnel worldwide our intolerance of drug abuse.

With regard to alcohol, we are using the momentum of the nationwide effort on drunk driving to drive home the seriousness and danger of this problem. We have directed our commanders to use the administrative, disciplinary, and educational tools available to prevent drunk driving and to deal with it firmly when it occurs.

Such insidious problems require a tough and concerted response from commanders at all levels, as I mentioned before. Consequently, senior leadership support, interest and guidance for the drug abuse program have been a constant theme in the Air Force and, we believe, the keys to our success.

We hold unit commanders responsible for program implementation and believe that our efforts will succeed through strong leadership and individual commander involvement and commitment. Our commanders fully understand that the aggressive pursuit of drug and alcohol abuse problems is an integral part of their responsibilities.

In terms of the current drug abuse situation I would like to emphasize several things. First, since 1974, our drug abuse prevalence rates, as measured by the various surveys, have steadily declined. Fewer of our people are using drugs today than at any time in the recent past.

Second, although drug abuse, to be sure, impacts duty performance, in no case have we experienced measurable unit readiness degradation due to drug abuse. These facts give us no cause for comfort but they do underscore the effectiveness of our efforts.

Recently we have made a number of changes to our program to refine it and strengthen it.

First, we redefined our policy and philosophy and made programmatic improvements for tighter management of drug abusers. These included a clear statement issued by the Secretary of the Air Force and the Chief of Staff that officers and NCO's must lead by example and that drug abuse by them is a serious breach of Air Force standards.

We set up a drug abuse evaluation programs at each base to insure commanders made full use of the various options available for disciplining and rehabilitating drug abusers. And we revised our drug abuse education program to help commanders address the drug abuse threat facing their commands more comprehensively.

We later had a special conference of commanders, senior NCO's and command representatives who proposed additional initiatives. Therefore, in October 1981, we extended the officer and officer candidate retention standards for drug abuse to NCO's, namely, your NCO and officer and officer candidate separation upon detection of drug abuse is the normal thing that we do.

We deleted the policy which stated that discharge is not normally appropriate for first drug offenders. We felt that this sort of policy encouraged young people to perhaps use drugs, and we tightened the drug abuse exemption policy eligibility criteria. These and the preceding changes significantly strengthened the program in a systematic manner.

While the above changes were being developed, the Secretary of the Air Force and the Chief of Staff reiterated Air Force drug abuse policy in a joint statement to all Air Force people on August 28, 1981, less than 1 year ago. Along with setting leadership responsibilities and expectations in regard to drug abuse, the Secretary of the Air Force and the Chief of Staff reminded individuals who continue to violate Air Force standards that, "they are jeopardizing their retention in the Air Force."

Such policy statements have reemphasized to all Air Force people that drug abuse is totally incompatible with the Air Force's mission and is not tolerated. Additionally, we are today implementing DOD guidance on the use of drug urinalysis results. These broad policy changes will allow evidence of drug abuse obtained from compulsory urinalysis to be used in disciplinary action and to support characterization of administrative discharges.

Further, as previously discussed, we have expanded our use of portable urinalysis equipment. We view the combination of this technical capability to detect marihuana, use through urinalysis and the ability to use the results in disciplinary proceedings as a major deterrent to marihuana use. Together with our use of portable equipment, these actions have given a clear signal to all of our people that we do not tolerate drug abuse.

Sir, that completes the summary of my statement.

Senator HUMPHREY. Thank you, sir.

Admiral Mulloy?

STATEMENT OF REAR ADM. PAUL J. MULLOY, DIRECTOR, HUMAN RESOURCES MANAGEMENT DIVISION, U.S. NAVY

Admiral MULLOY. Thank you, sir. I am honored to be in these chambers and I am proud to be in this uniform. I came aboard in August

after 6 years at sea where I was privileged to have three major commands. I share your appreciation for those magnificent sailors.

We shared, Mr. Chairman, with your staff members what our programs are, so I will briefly go over them.

Prompted by the Congress, the DOD survey in November of 1980, which was followed by the Navy's urinalysis-based survey, was a benchmark. CNO declared war in a 10-point program, accelerating it in November 1981. In December 1981 wrote a NAVOP about "Help and Hammer," the "get tough" policies; and we put it into execution in February 1982.

The reports from the Fleet CINC's and other second echelon commanders as recently as 2 days ago indicate that it is winning, the abuse is down: The people are coming across looking for treatment and the numbers of court cases are increasing for the traffickers with heavier sentences. I had the occasion over the weekend to read Senator Jepsen's expansion of the UCMJ, and I very much appreciate that, sir. That is going to help because for those who do not get the word or fully understand the implications, that is going to get it across.

Our drug detection dogs, the portable unrinalysis kits, the prevention, detection, deterrence methodology, which is the new shift in our program, are working, taking hold. The CNO's message is clear. The young lads who are saying, "This is getting too hot and are turning away from drug abuse. A lot of the younger sailors are saying things like, "It's about time." And also, we have people saying, "I am not going down alone." That tells me that our two-prong effect of enlightened leadership from the Flag down to officer, the most junior petty officer and the peer group pressure comes across depicted and is taking hold.

The statistics that we have so far are measurable, there is a definite decrease. We are trying to quantify it better now that we are getting our management information system, that we have in our 10-point program onboard. It should be online by September.

The Fleet Commanders stress that the numbers of occurrences are down. That means the programs are working, including searches. The proposed changes to the postal regulations that Congress urged are super. For the Navy they are particularly effective, as are the portable urinalysis kits. The kits and the dogs are sending clear signals. I am proud of what we are doing. I am particularly pleased with what some families report. The letters are showing that the family service centers are working effectively in the area of drug abuse and that all of these methods are strengthening what we are doing out there against this.

It includes getting the families involved because we feel that is another very important element of solving this problem.

So, we are excited about what we are doing, we are proud of what we are doing. and we are pleased with the congressional support and we know with that we are going to win this war.

Thank you, sir.

[The prepared statement of Rear Admiral Mulloy follows:]

PREPARED STATEMENT OF REAR ADM. PAUL J. MULLOY, U.S. NAVY, DIRECTOR, HUMAN RESOURCE MANAGEMENT DIVISION, OFFICE OF THE CHIEF OF NAVAL OPERATIONS

Mr. Chairman and members of the committee: I am Rear Admiral Paul J. Mulloy, serving since August on the staff of the Chief of Naval Operations as

the Director, Human Resource Management Division. It is my privilege to address you concerning the Navy's aggressive efforts in waging its war on drugs.

I want to take this opportunity to publicly thank each of you on behalf of the Chief of Naval Operations, for the tremendous support you have given us in meeting this problem head-on. Having had the honor of speaking personally with several members of the Senate about this issue. I have been impressed with the enthusiastic support for our "get tough" policies and actions against substance abuse. This solid backing is more than just appreciated. It is absolutely vital to the success of our programs in combatting this menace to national security.

Our war against drugs is being fought on several fronts using various weapons. On the detection and deterrence front we have our drug detection dog teams and our urinalysis equipment. The drug dog teams have proven themselves as an effective means of sniffing out illegal drugs, and, in fact, their very presence is a deterrent. Using Air Force training facilities, we will significantly expand our dog and handler teams this year. Also in the detection and deterrence arsenal is our portable urinalysis equipment. Because of new technological breakthroughs which enabled us to detect cannabis we can now target this equipment also against the most prevalent drug of choice. We hope to contract with the manufacturer of this portable equipment to purchase over 250 of these briefcase sized kits and have them distributed by the end of this fiscal year. We are also significantly expanding the capabilities of the four drug screening laboratories supported by the Navy as part of the Department of Defense world-wide network of eight such laboratories. Revised DoD policies now allow us to use the results of certain laboratory confirmed urinalysis tests for disciplinary purposes. This has provided us with a powerful deterrent which we did not have in the past. Also, policies have been rewritten to provide other than honorable discharges for misconduct due to drugs for offenders.

We now have in place four forensic laboratories at Naples, Norfolk, San Diego and Pearl Harbor which greatly improves the competencies and responsitivity of criminal investigations. In 1981 the Naval Investigative Service (NIS) completed 5,571 narcotics investigations: about a 40 percent increase over 1980. During the first 2 months of this year NIS opened 1,250 more investigations which, projected out, is a 25 percent increase over last year. NIS increased its special agent strength by hiring an additional 185 men and women since December 1980. NIS now has 710 special agent personnel world-wide. The results are impressive. Convictions of serious offenders, officer and enlisted, have resulted in imprisonment at hard labor and dishonorable discharges.

On the education and training front we are in the midst of a Navy internal "media-blitz" which is aimed at providing hard facts on the dangers of drug and alcohol abuse to everyone in the Navy, from command to mess deck. Our best weapon is information in any and all forms. We have produced video tapes for fleet-wide distribution, published articles in our regular weekly Newsgram message and mailed out packages of anti-drug and alcohol abuse literature. All our formal training schools have curricula which specifically discuss the problem of drug and alcohol abuse and all are being revised to include the latest authoritative information on substance abuse to improve leader knowledge and effectiveness.

Our treatment and rehabilitation policies are being modified to ensure that those who need help are given assistance at the most appropriate level. By that, I mean people who are abusing drugs or alcohol because it's the popular thing to do are now dealt with primarily at the unit level. They are given direct attention by appropriate disciplinary action (if warranted) and/or corrective reeducation through our drug or alcohol safety action programs. This approach has proven effective in the past. It engages the problem right at the ship or unit level where shipmate leadership and peer pressure can be effectively applied. We are now restricting the more expensive residential treatment to only those individuals whom the Commanding Officers judge to have a good potential for further useful service. Those who do not possess such potential will not be retained in the service. We are convinced that most of our repeat drug abusers are primarily disobedient people who refuse to adapt to the time honored and tested rigorous standards of our naval service. They are not addicted to drugs in the commonly accepted meaning of that term. They are maladaptors who disrupt the close-knit trust, confidence and combat effectiveness of their shipmates. By their attitudes and behavior they have indicated they don't want to be in our all-volunteer service and we don't want them aboard.

This is why we have implemented procedures to start clearly and strongly in boot camp and to closely observe our new accessions all the way through their initial training. We are quickly weeding out those who challenge our high standards. And not just boot camp, for this applies to both enlisted recruits and new officer candidates. Even so, the traditional helping hand is still there and always will be. Our drug and alcohol rehabilitation centers are the best in the world and will continue to be. As the Chief of Naval Operations clearly stated, we will help those who seek help. For those that don't and abuse drugs, we'll hammer them. The safety, combat readiness and esprit de corps of our vast majority of superb shipmates demand no less.

The effectiveness of our programs is being monitored by various assessment and evaluation techniques which include surveys and reports. We have taken positive steps to enhance our data gathering capabilities by expanding our Navy Alcohol and Drug Information System. This computer system should be on-line by the end of this year. It is too early yet to determine exactly how successful our "get tough" policy has been. Commander reports are very enthusiastic. We expect the answer to come from the results of the DOD world-wide survey to be conducted this fall. In the meantime, our best subjective measure of how our policy is being received comes from the messages citing enforcement actions. urinalysis results, and clear downturn of drug abuse from the effects of all these measures. Perhaps our best measure of evaluating how all this is being received comes from the many sailors on ships and squadrons who have said quote, "It's about time." unquote.

I wish to include also that we are well aware that alcohol is still the No. 1 substance of abuse. And since our crackdown on drugs, the increasing shift to alcohol abuse is being noted as we expected. However, we anticipated this effect and increased our resources by 14 percent this year and will request an additional 21 percent next year to cope with that perennial problem. We are currently assessing stronger measures to deal with alcohol abuse and, in fact, are preparing a total reorganization to deal with "substance abuse" in a uniform manner.

We are confident what we're doing is the right thing for national security. With your continuing support and the growing public awareness and resolve, I know we'll win our "War on Drugs." Thank you for permitting me this opportunity to share this progress report with you and to assure you of my commitment and enthusiasm in helping our beautiful shipmates win.

Senator HUMPHREY. Thank you.

General Mitchell?

STATEMENT OF BRIG. GEN. JOHN H. MITCHELL, DIRECTOR OF HUMAN RESOURCES DEVELOPMENT, U.S. ARMY

General MITCHELL. Mr. Chairman, the Army counts this as a unique opportunity to tell its story with regard to the fight for freedom from drug and alcohol abuse. We have had a program in effect for over a decade. It is a comprehensive program which is coming to greater maturity with each passing year.

It is dedicated, as are the other service programs, to the eradication of the effects of drug and alcohol abuse in the force. Most recently our regulations were changed, in January of this year, to change the thrust of the Army's program from rehabilitation and treatment to one of deterrence, prevention, and education. That does not mean to suggest that we are not still interested in treating and returning people to duty, but we have changed some emphasis.

The Chief of Staff, the Secretary of the Army, have spoken out privately and publicly with regard to the Army's policy, opposed to the use of alcohol and the use of illicit drugs. Most recently at Carlisle Barracks the Chief of Staff gathered his division commanders and they made that a primary point of their discussion among that group of leaders.

We are developing an Armywide deterrence-oriented education plan which will be progressive in nature. We have had one in place but it has not in fact been a comprehensive or progressive plan for educating both the leadership and the at-risk population. By August we expect to have this in full operation for the basic training through the War College at Carlisle Barracks.

Part of our education program is to develop a series of video tapes and films which will demonstrate not only to the leadership but to the population at risk that the effects are ones that will perturb proper performance and the ability to be ready for primary mission.

We are deeply concerned about especially three high-risk target populations in the military: Those in the personnel reliability program, the aviation community, and the military police. We either have in place or are in the process of developing a policy to put in place, special safeguards and constraints on the activities of these individuals so as to make them safer from the prevalence of this problem.

Our Criminal Investigation Command with each passing fiscal year has shown evidence of greater suppression of trafficking. Most recently, in fiscal year 1981, $181.8 million were of contraband associated with this problem—seized; a $44.3 million increase over the previous fiscal year.

The additional authority that has been mentioned by Dr. Beary in that we may now use urinalysis results as evidence. The testing and availability of portable kits for drugs and breath testers for alcohol are strengthening the hand of our commanders and we expect to see substantial results in that area.

We are expanding our residential treatment facilities which are principally devoted to the problem of alcoholism. We have three such facilities in use now, one here in the United States; one in Germany, and one in Korea. I expect to establish a fourth in the United States in this fiscal year, which is 2 years ahead of our program plan.

Mr. Chairman, I can assure you that the Army indeed is dedicated to eliminating this problem within the forces, and we believe we have a program and a leadership dedicated to do that.

Thank you.

[The prepared statement of Brig. Gen. John Mitchell follows:]

PREPARED STATEMENT BY BRIG. GEN. JOHN H. MITCHELL, DIRECTOR OF HUMAN RESOURCES DEVELOPMENT OFFICE, DEPUTY CHIEF OF STAFF FOR PERSONNEL, DEPARTMENT OF THE ARMY

Mr. Chairman and members of the committee, I am Brig. Gen. John H. Mitchell, Director of Human Resources Development, Office of the Deputy Chief of Staff for Personnel, Department of the Army.

I appreciate the opportunity to appear before this committee to discuss the Army's Alcohol and Drug Abuse Prevention and Control Program.

The Army has set into motion a tough new plan to give the nation a more competent Army, purged of all unproductive, disruptive, and divisive elements possible. In that context, the Army's alcohol and drug program is founded on the uncompromising conviction that alcohol and drug abuse are incompatible with military service. Accordingly, the Army will continue to attack substance abuse with the full arsenal of preventive, investigative, administrative, disciplinary, and rehabilitative leadership tools. Rehabilitation programs are justified, however, only to the extent that soldiers respond to therapy and counseling; those who fail will be separated.

We will continue to rely upon centralized management and decentralized execution. We are convinced that this societal problem will yield best to locally applied leadership skills, backed up by competent legal and clinical advice and disciplinary tools.

Correspondingly, the Army has increased its command emphasis. The Army Chief of Staff made the subject a priority item of discussion during the Army Commanders' conference in October 1981 and again with his Division commanders in December 1981. The most recent emphasis was last month in a conference call to all major Army commanders.

An "on-line" management information system is being implemented. This system will provide a method for comprehensive analysis of information from all sources, i.e., medical, disciplinary, enforcement, and programatic.

We are developing an Army-wide, deterrence-oriented, education plan on drug and alcohol abuse. We will start with educating the new recruits by making them aware of the Army's firm stance on alcohol and drugs. Education will continue throughout the soldier's service. We are also taking steps to increase the education and awareness levels of commanders to include training in alcohol and drug abuse issues during precommissioning courses, basic and advanced courses, command and staff and senior service schools.

As a part of our education and awareness effort, we have recently produced the first of a series of videotapes which discuss the effects of marihuana on combat readiness. These tapes will receive Army-wide distribution. A special target of this effort is a film to demonstrate the effects of alcohol and marihuana on aviators.

We are deeply concerned about drug and alcohol abuse at sensitive installations. Nuclear weapons, military police, and aviation units receive special attention to ensure a general atmosphere of order and discipline. Commanders are giving great attention to these problems and are disqualifying those found to be abusing drugs. Urinalysis testing at the Aviation Center, Fort Rucker, Alabama, has been substantially increased.

U.S. Army Criminal Investigation Command drug suppression activities throughout the world have proven highly successful in combating drug possession and trafficking. Calendar year 1981 Army law enforcement actions resulted in seizure of illicit drugs valued at $181.8 million, up from $137.5 million in calendar year 1980.

Additional authority and new portable testing capabilities will help us in our fight against substance abuse. We have received authority from DOD to use the results of urinalysis tests to support disciplinary actions under specified conditions. Implementing instructions and procedures have been issued. We will monitor results to determine any change in the deterrent value of the urinalysis program. The field-testing of portable breathalyzers is ongoing and may give us the capability of determining levels of on-duty alcohol use. Portable urinalysis test kits are also being field-tested to validate their applicability as an additional deterrent to drug use.

We are revitalizing our counselor certification so as to standardize the rehabilitation services offered soldiers and improve the professionalism of our counsellor staffs. Efforts are also being taken to expand our residential alcohol treatment capabilities. The Army has one in Germany, Korea and the United States. We plan to add one more this year. This action is well ahead of the originally planned start time of fiscal year 1984.

I can assure you that we are making a concerted effort to minimize the effects of alcohol and drug abuse on the operational readiness of the Army.

Thank you Mr. Chairman, I will be happy to answer your questions.

Senator HUMPHREY. Thank you.

General Lukeman?

STATEMENT OF BRIG. GEN. ANTHONY LUKEMAN, DIRECTOR, MANPOWER PLANS AND POLICY DIVISION, U.S. MARINE CORPS

General LUKEMAN. Thank you, sir. I would like to first quickly summarize the Marine Corps' program in five ways.

First, we have set unequivocal standards which say that we are not going to tolerate the use of any illegal drugs by Marines.

Then we have made our leaders responsible. They set the specific conditions that are going to make their men want to do what is best for their units and make sure that their men understand the risks and the penalties when they use illegal drugs.

We get the majority of the Marines, that is those who are not using drugs and do not want to have anything to do with drugs, involved in the process and make them responsible for their fellow Marines.

Fourth, we do everything we possibly can to identify any marine who does use drugs, and finally, we take a firm action in every case where we discover that a marine has done that.

All of this is totally consistent with what we believe is a fundamental responsibility, to take care of our individual marines—the rifleman, the machinegunner, the aircraft mechanic.

In the units that take these individuals together and give them direction and a mission, are leaders who provide the inspiration to make it all happen, and the discipline that makes each one of us and our units able to move out and get the job done and not stand around and philosophize about it.

It seems to be working. We have some positive indicators. We are simply not finding the same number of drugs in our barrracks inspections now that we were four months ago.

Voluntary disclosures and requests for assistance have doubled over the same period last year. At one base the commander went out and asked for volunteers to help in forming teams of drug counselors and he got more people than he could handle in his drug and alcohol abuse section.

At another base, volunteer NCO's go with the marines who have been identified as drug abusers to reeducation classes and then lend support to these marines back in their units.

Unauthorized absence is down 12 percent in the first 6 months of fiscal year 1982 as compared to the same period last year. Desertion is down about the same. Serious crime is down 15 percent in the Marine Corps during the first 4 months of 1982, compared to 1981.

Sale and possession of dangerous drugs is down 30 percent in the incidents that have been reported to the provost marshal. Misconduct discharges, which are very often associated with drug abuse, are up 10 percent in the first 6 months compared to a similar period over the last 3 years.

I talked to four commanding generals this morning before I came to this hearing to get some recent on-the-spot feel for what is happening out there, and I want to share one incident with the members of the subcommittees.

The commanding general of the 2d Marine, Aircraft Wing had a marine who was stopped at a gate search. He was tested on a portable urinalysis kit, was found positive, and started a 30-day program in that unit. After 25 days he came to his commanding officer with tears in his eyes and he thanked him for helping him turn his life around. And, Senators, this is happening all over the Marine Corps today.

I read the letters from mothers, from the people outside the gates of Marine bases, and the program is getting the kinds of results that we are looking for.

Thank you, sir.

[The prepared statement of Brig. Gen. Anthony Lukeman follows:]

PREPARED STATEMENT OF BRIG. GEN. ANTHONY LUKEMAN, U.S. MARINE CORPS, DIRECTOR, MANPOWER PLANS AND POLICY DIVISION

Mr. Chairman, members of the committees, the opportunity to appear before you today and discuss the Marine Corps programs and initiatives to combat the use of illegal drugs and the abuse of alcohol is most welcome. I will briefly review our program and procedures to convince Marines who are using illegal drugs to stop.

The use of illegal drugs constitutes a disregard for discipline and organizational values and adversely affects the physical and psychological health of individuals. Marine Corps policy in this area relies on a total leadership effort of every Marine officer, staff noncommissioned officer and noncommissioned officer, to ensure that Marines recognize that the use of illegal drugs will not be tolerated and to elicit the enthusiastic participation of Marines who do not use illegal drugs in influencing their peers in a positive way.

The fundamental foundations of this policy are leadership and acceptance of the established standard. We recognize that young Americans enter the Corps with certain values, attitudes and predispositions about drugs. Many of these are changed at recruit and officer training as new Marines are indoctrinated with the positive values consistent with the high standards of the Corps: esprit and unswerving loyalty to country and Corps, self-discipline, individual and unit pride, desire to reach individual capabilities, physical fitness. We are reinforcing in our Marines an attitude of intolerance toward illegal drug use and nurturing a spirit of unit integrity based on a truly ready, drug free band of brothers through intelligent leadership, early identification of the illegal drug user and strict enforcement of standards. Involvement of leaders at all levels is mandatory.

The officer ranks' acceptance of this established standard is manifested through leadership by example. Leaders becoming involved with illegal drugs in any manner would be particularly damaging to the overall effort of eliminating drug use in the Marine Corps; therefore, our policy towards commissioned officers and warrant officers who use illegal drugs is unequivocally strict. They are processed for separation under other than honorable conditions. When appropriate, trial by court-martial is directed.

An enlisted Marine who uses or possesses illegal drugs for the first time is subject to appropriate judicial or administrative action. If the Marine's overall conduct/performance record, and the circumstances surrounding the first-time drug involvement indicate a potential for continued service, the Marine will be retained in the unit; those first-time offenders who are retained undergo a local command course of instruction. Where the review of the Marine's record shows a pattern of misconduct or no potential for continued service, the Marine is processed for separation. Any Marine found using or possessing illegal drugs a second time normally is processed for separation for misconduct, in addition to any nonjudicial or judicial punishment. In special circumstances where the commander determines that the Marine may still have potential for continued service, treatment and further evaluation are provided. No Marine who has been identified using or possessing illegal drugs a third time is retained in the Marine Corps.

The Marine Corps recognizes no responsibility to retain or rehabilitate drug traffickers. The disposition of individuals who traffic in illegal drugs in any amount is accomplished through existing administrative and legal channels.

Enlisted Marines who use or possess illegal drugs for the first time, who are not drug dependent, and who appear to have potential for continued service are assigned to a locally established course of instruction. Marines remain with their units during this period and continue to perform regularly assigned duties. Professionals and paraprofessionals, such as drug counselors, medical officers, judge advocates and chaplains may participate in the instruction, but the most significant element of the instruction is the active involvement of unit leaders. The following subjects are covered:

(1) The overriding importance of individual discipline to a strong and effective Marine Corps.

(2) Hazards to health, family, and personal lives resulting from illegal drug use.

(3) Marine Corps policy regarding illegal drug use or possession.

(4) Legal and administrative consequences of illegal drug use or possession.

(5) The development of teamwork, honesty, honor and reliability in garrison and combat environments.

(6) Responsibility of Marines to take care of their own.

At the conclusion of the course of instruction, the Marine's commander makes one of two decisions: full duty or process for separation.

Major command treatment programs for individuals requiring additional education include screening, medical evaluation, remedial education, treatment, and follow-up assistance. These programs are structured to provide more concentrated remedial education for the illegal drug user who still has potential for continued military service. Additionally, major command programs provide subordinate commands with evalutaions, recommendations, treatment, medical diagnosis where deemed appropriate, and referral to residential treatment and rehabilitation in those cases where the individual is drug dependent. Evaluation during this program determines whether the Marine is restored to duty or separated.

The Marine Corps uses the Navy residential treatment facility at Miramar, California for those members determined to be drug dependent, yet still judged by their commanders to have extraordinary potential for continued military service. Successful completion of the course at the Navy Drug Rehabilitation Center (NDRC), however, is not a guarantee that the individual will be retained in the Marine Corps. Marines successfully completing the course of instruction are evaluated for a 90-day period by their commanding officer before final disposition is made, regardless of the NDRC evaluation/recommendation. Marines terminated from treatment for any reason other than successful completion are processed for administrative discharge. In these cases, the 90-day evaluation period is waived.

Individuals who are medically diagnosed as drug dependent, but who do not have potential for continued military service are considered for treatment at a Veterans Administration facility in conjunction with an appropriate administrative discharge.

Marine Corps education and prevention programs generally combine consideration both of illegal drugs and abuse of alcohol. They are aimed at modifying and strengthening individual attitudes away from the use of illegal drugs and alcohol abuse through leadership, identification of illegal drug users and strict enforcement of standards. An additional objective is to educate military and civilian supervisory personnel concerning their role in the prevention efforts, using their leadership to influence subordinates to reject illegal drug use and alcohol abuse.

Education and training is provided to Marines during initial training for all new accessions (officer and enlisted), during attendance at all Marine Corps formal schools, within sixty days of reporting for duty on permanent change of station orders and within thirty days of arriving at a new overseas duty station.

A Marine Corps Drug and Alcohol Program Evaluation Team provides the Commandant with direct field representation for analyzing the effectiveness of drug and alcohol education and prevention program. It also provides assistance and guidance when required in interpreting and applying Marine Corps orders concerning illegal drug use and alcohol abuse control programs.

In our alcohol treatment program, the Marine Corps seeks to prevent and deter alcohol abuse and alcoholism: to restore Marines who have abused alcohol to full duty when possible; and to provide for the discharge and referral to the Veterans Administration and other appropriate civilian agencies of those members who are unable to successfully complete a treatment/rehabilitation program and continue as effective Marines.

The treatment process begins with identification. Commanders at the regimental/group level and below provide screening, remedial education, and referral of abusers for further evaluation. The program at this level is nonclinical and consists of leadership counseling, education, initial screening and referral to a specialist. The thrust of the treatment program is to provide an environment in which the abuser is supported and assisted in efforts to become a responsible, productive Marine and a mature individual.

Major commands, i.e., Marine Aircraft Wings, Marine Divisions, Force Service Support Groups, Marine Corps Bases, and Marine Corps Air Stations conduct more extensive programs of education for the occasional problem drinker, and treatment for the habitual problem drinker.

If an individual is diagnosed as alcohol dependent, he is referred to residential treatment in a Navy-managed rehabilitation facility. Upon successful completion of the rehabilitation program, he returns to his parent unit. If the Marine fails

to cooperate in the treatment/rehabilitation effort, he is considered to be unsuitable for further service and administratively separated.

Before concluding this statement, I want to reemphasize the overriding importance of informed leadership. Our instruction to Marine commanders throughout the world lays the task out clearly. It says in part:

"Marine Corps leaders must be capable of convincing Marines in their charge that the use of illegal drugs is fundamentally wrong and destructive to organizational effectiveness. Leaders must also encourage each Marine to assume responsibility for exerting peer pressure on fellow Marines to help them avoid the consequences of illegal drug use.

An important part of the effort is to change the attitude of Marines toward drugs; to reinforce the view that every Marine has a responsibility for the lives of fellow Marines; and to help group peer pressure to get the job done. A total effort is required.

One of the most difficult leadership requirements facing commanders is to influence their enlisted Marines, particularly the natural leaders among their peers, to apply peer pressure and encourage their fellow Marines to reject the use of illegal drugs and reject those who continue to use illegal drugs. Meeting this requirement will ensure success of the entire effort by reinforcing leadership with peer pressure to continuously emphasize desired organizational values. This aspect of the leadership effort should be emphasized strongly and receive priority command attention.

Use of illegal drugs and progress toward eliminating them will be included as a topic for discussion on a regular basis at staff and commanders meetings, officers/staff noncommissioned officers/noncommissioned officers schools, and scheduled informational training periods at the organizational level.

Recognizing that boredom can contribute to experimentation with and use of illegal drugs, commanders should emphasize vigorous programs specifically designed to involve Marines in healthy and productive off-duty activities. Attention should be placed on gaining maximum participation of Marines, particularly bachelor Marines, in intramural sports programs and other competitive activities conducted outside of normal duty hours in the evening and on weekends. Special programs to interest Marines in using existing recreational facilities should be initiated.

Commanding generals, commanding officers and officers in charge will assure individual attention, reporting and followup action in every instance of the use of illegal drugs. In this regard, it is particularly important to recognize that those Marines who are not separated from the Marine Corps as a result of first time drug use be allowed to prove themselves. Consequently, no action should be taken that is degrading or that otherwise would influence the individual to act in a manner other than as a proud Marine who made a mistake and wants to overcome it.

The responsibility of commanders to eliminate the use of illegal drugs does not stop at the front gate. Aggressive programs should be established, in cooperation with local authorities, to attack illegal drug activities in communities surrounding Marine Corps installations.

In summary, Marine Corps programs to prevent illegal drug use and alcohol abuse depend on a total leadership effort. Leaders at all levels are charged with becoming thoroughly knowledgeable on illegal drug use and alcohol abuse, and of convincing Marines in their charge that the use of illegal drugs or the abuse of alcohol is fundamentally wrong and will not be tolerated; that it adversely impacts unit readiness; that it is destructive to the health of the individual; and that failure to respond positively to Marine Corps standards will result in appropriate disciplinary action or adverse administrative discharge action. An important part of this effort is to reinforce the view that every Marine has a responsibility for the lives of fellow Marines. The combination of education, identification, enforcement of standards and assistance to Marines who have the potential for meeting those standards is designed to eliminate the use of illegal drugs and the abuse of alcohol as detractors from organizational effectiveness.

Senator HUMPHREY. Thank you.

Senator Jepsen?

Senator JEPSEN. Thank you.

I appreciate the upbeat optimism about handling the drug problem.

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The last was very refreshing in that it does sound as though you have a program going that has a nice mix and blend in the fabric of the program with discipline and identification, just what the purpose of the Marine Corps is, and what their mission is.

Without you saying so, I would guess that is woven into the fabric of the entire five-step program—they are moved, communicate, shoot, and provide for national security; which is the first mission. It is not a social club.

And along those lines, Dr. Johns, I was interested in your comments about the—I am paraphrasing now—new way of approach, the community spirit, if you will.

It seems to me we lost some of the identification of just what the real goal was. It may have been this transition from the draft to this volunteer item. But you know, when an individual goes into the service, he submits some of his or her personal comfort, and ideas, and so on, to that of the unit. The unit performance rules the company's; the company's performance rules the battalion, and so on.

One of the threads of that type of a philosophy and process is, of course, discipline, identification of the goals, and then the resolve to follow through.

Would you comment, Dr. Johns, on rule 1 of this? I believe you said that the community-type spirit approach was more than just a drug program. Could you elaborate on what the Defense Department is doing?

Dr. JOHNS. Drug abuse, really, is just one manifestation of the lack of commitment on the part of members of an organization that you get when you have a feeling toward your organization that it is just a job, that you have a contractual relationship to your organization, and you give them so much effort for money in return.

The scientific literature is very clear on this point and that kind of commitment does not get the conformity to the norms of that organization that you have when there is a moral commitment to the organization. And moral commitment comes when you belong to an organization because you accept the values and norms, or standards of behavior as your own, as being right, not just because you have a contract to do them.

We believe that the scientific definition of "cohesion" comes only when you have that kind of moral commitment. Now, there are many, many factors that will shove you from that kind of institution to one that is just a job. I will not go into details of those, I think you are accurate in saying maybe some of them are associated with the All-Volunteer Force recruitment and emphasis on econometrics. But I do not think the All-Volunteer Force had to go in that direction.

Senator JEPSEN. Well, I do not think so, either, but lots of things happened. In 1972, the Gates Commission concluded that in order to sustain new recruits into the military under an All-Volunteer Force concept, it would be necessary to pay junior personnel larger salaries and make living conditions in semiprivate rooms instead of barracks, when the fact is, you have much less structure and free time.

In your opinion, have these factors, coupled with this less structured environment and more free time, contributed to the drug abuse problem in the military?

Dr. JOHNS. In my opinion, yes, sir. I think that you can go to a libertarian type system and let each person decide his own free use of time and so forth to the extent that the organization no longer has meaningful control. I think some of that has happened in the military. But I see a turning around of that. I have just completed a research study on cohesion in the military and I interviewed six out of the eight top brass. They are very clearly aware of this and are taking measures to go back to a more traditional type military organization.

Senator JEPSEN. That was quite accurately voiced here earlier by Dr. Beary, I believe. The glamorization of drugs as the thing to do plays a very key role. Just look at the cigarette advertising, the glamor of it. You always see somebody coming out of a pool, dripping ice-cold water, looking refreshed, all tanned and healthy and running to smoke a cigarette real quick.

Now, the deglamorization of drugs, it seems to me, would be a very key part of a program, especially in the military where you at least have a semblence of a controlled situation. Is that, Dr. Beary or Dr. Johns, high on the priority list? What are you doing in that area?

Dr. BEARY. Yes, deglamorization is on the priority list. So, we are issuing a sort of policy guidance that hopefully will let one see less of the "Happy Hour" situation that alcohol is an inevitable part of. And any place where we can set an example ourselves, such as minimizing the service of alcoholic beverages in social settings. A thought as to how much of a liquor ration somebody would get is another example. We all are starting to look at our personnel policies in terms of the effect on cohesion. We think about things like, is it a good idea to decrease basic training? Maybe it should be increased so that these values can be better inculcated into these young people.

So, that is the general theme that drives us as we consider each of these issues. John, would you have anything to add on deglamorization?

Dr. JOHNS. I think that one of the five major goals that Dr. Beary has set for the Health Affairs Office is what we call health promotion and is stated in the form of creating cohesive military communities and organizations with values and norms that promote individual physical and mental well-being for the entire community, including the families. It is stated in a very positive way.

Included in that kind of goal is deglamorization of any kind of life style that would promote unhealthy mental or physical well-being.

Senator JEPSEN. How about some good old-fashioned films like we used to have on VD? I can attest to it, a 17-year-old farm boy coming into the service. It gave me a real different outlook, a real outlook—I should not say different—a new outlook very, very quickly. [Laughter.]

You have the film of withdrawal and some of these people are vegetables; people with their arms poked full of holes; people blowing their minds; their nose and eyes running, they are twitching, ticks, and all sorts of things which is really what happens.

What is the matter with showing them something like that? I mean, that is real. We seem to touch it with a powder puff and talks about cohesion—why not tell it like it is?

Dr. JOHNS. Well, we do both, though. We have recently contracted and developed 13 TV spots and 13 radio spots that we show in the

Armed Forces' closed network. We developed a pamphlet, easy to read, with Dr. DuPont, the National Council on Marihuana, talking about the bad effects of marihuana. It very clearly lays out what the National Academy of Science has said about the bad effects of marihuana.

I know the Navy and the Marine Corps have just distributed a film on marihuana.

Admiral MULLOY. We have several different movies that went out recently, Senator Jepsen. In fact, we have talked to Tulane University about providing us with films on the effects marihuana has on the brain of Rhesus monkeys. We are having those expanded in conjunction with the Journal of the American Medical Association's October issue on marihuana as a dangerous drug. This actually shows those kids what happens to the brain and other vital systems of the body.

We have a film that is underway right now with a motor vehicle accident where there is no alcohol abuse but rather it is drugs. It has the gore and shock value that we used to see in drunk driving films, plus peer group pictures. There are a number of different ones since December, honing in on shock effect as well as educational, scientifically sure data. It is out there and it is having the effect you described. They are paying attention to it.

Senator JEPSEN. My time is up. I will come back. Thank you.

Senator HUMPHREY. Dr. Beary, I want to establish some line of authority and responsibility here. You are the top official in the Department of Defense who has responsibility for these programs?

Dr. BEARY. That is correct, sir.

Senator HUMPHREY. And Dr. Johns comes directly under you and the military officers; is that correct?

Dr. BEARY. That is basically the arrangement. I might emphasize that the OSD Office tends to set the broad policy and leaves the details of implementation to the services.

Senator HUMPHREY. There are clear lines of authority established.

Dr. BEARY. Yes, sir. I feel very comfortable with the policy that is set forward, that we get very good cooperation. As everyone knows, we all work for the Secretary of Defense.

Senator HUMPHREY. Dr. Beary, what is the effect on preparedness of the problem with alcohol and drug abuse, has that been quantified in any way?

Dr. BEARY. It has not been quantified. Commonsense would have to tell you that preparedness is not as good as it would be without it. But at the same time, when our divisions and fleets participtate in readiness exercises they do quite well.

John, is there anything you would want to add to that?

Dr. JOHNS. The most difficult thing we have to do, is assess in a quantitative form the impact on readiness. I talked to commanders all the way from the bottom to the four-star level and they will all say, "We are combat ready." And we do have the best record. In Europe the Air Force had the best record in the history of the Air Force last year. The Navy and Marine Air had, I believe, the best safety record in history. But it does impact some.

Senator HUMPHREY. Well, you mentioned conversations with commanders. There was a report issued by a House committee on this subject. It seemed to indicate that in field interviews with commanders,

they felt that there was a real effect. The impact of this problem was felt when a service member was separated or shunned into a rehabilitation program, he or she was then not available for any other duty. That is disturbing testimony because we all know that it has to affect people while they are performing their jobs, as well as when the impact of their separation is felt.

What about the more demanding skills, piloting aircraft or driving tanks, operating tanks, things of that nature. Have there been any studies or are any studies contemplated to measure the effect on readiness of performance under the influence of alcohol or drugs?

Dr. BEARY. Yes, sir. I am speaking as a former flight surgeon and was very much oriented to doing the kind of work you are alluding to there.

That was a subject that concerned me immediately upon my arrival a year ago at the Department, that that data just was not available. Therefore, we are putting together protocol, really, to secure for the first time direct observations of people at these sensitive duties and make those judgments.

Senator HUMPHREY. When will that study be concluded?

Dr. BEARY. The protocol is being written now, and this autumn, Dr. Johns, do you think we would have the team assembled and prepared?

Dr. JOHNS. Probably after our meeting with officials of the National Institute on Drug Abuse on the 27th of this month we will finalize the approach that we want to take on that. Then we will staff it with the services to see that they enthusiastically agree with the study.

Senator HUMPHREY. Let me ask a question of each of you gentlemen. What is the effect on readiness in the Air Force of drug and alcohol abuse?

General USHER. As I mentioned in my summary, of course, we are concerned about any abuse as having some effect on our readiness. However, as I also mentioned, measurement systems for readiness, how our units perform, do not indicate that there is any measurable effect. I think that is fairly logical.

Senator HUMPHREY. Are you saying that someone who is high on alcohol or drugs is able to perform his task as well as someone who is not?

General USHER. Obviously not.

Senator HUMPHREY. Then there has to be some effect.

General USHER. There is a small effect, to be sure.

Senator HUMPHREY. I am not sure that a small effect is something that I could receive credibly. I am beginning to think that perhaps the Department of Defense is deficient in not studying the problem, trying to put into quantifiable terms the problems of alcohol and drug abuse. It seems to me that is an aspect that has been glossed over here.

General USHER. Well, of course the last survey that was a comprehensive survey was done 2 years ago. At least as far as the Air Force is concerned it indicates in terms of drug abuse any time during the last year on duty was about 8 percent. A significant figure, to be sure, but still a relatively small one.

The E–1's to E–5's who were impaired by alcohol on duty in the last year was about 7 percent. Now, that gives us no comfort, to be sure, but it does give us a level of indication. It indicates to us that some of

the programs that we have been pursuing are having their effect and are reducing this incidence.

So, I think that although we do not accept any effect on readiness I must reiterate that our measurement systems so far have not shown that there is a remarkable effect on the capacity of our units to perform the work of our mission.

Senator HUMPHREY. Admiral Mulloy, has the Navy quantified the effect on readiness of alcohol and drug abuse?

Admiral MULLOY. Mr. Chairman, the reporting system, the unit readiness system has shown no measurable impact.

Senator HUMPHREY. That casts further doubt on the system because we know there is an effect. Maybe others are working harder to offset those who are not capable of putting forth 100 percent.

Dr. BEARY. That is probably a useful distinction to make about effects on individuals and effects on units. Your comment, I think, shows there are two factors.

Senator HUMPHREY. Excuse me, go ahead.

Admiral MULLOY. We have designed our readiness reporting system around the ship's ability to perform up to its capability. The numbers that came out of the surveys were very disturbing to us.

Now, what is happening since we went to war on drugs is, there is a reduction, prevalence of abuse is coming down. There have been no reports from any commanders on the impact drug abuse has had on readiness. What we will see is that as we get our management information system in place, for each individual that crosses the line with regard to drugs or alcohol, there would be a report kept and we can quantify how many and then see if we can correlate it. There is no impact on a ship, or a squadron of aircraft, that has been reported. And with the reduction that is going on we feel that we are on track.

It is not a good answer to what you ask. There is not any system out there yet that would answer your question.

Senator HUMPHREY. Do not misunderstand me. I am not trying to be critical. I am trying to find some areas where perhaps improvement is in order.

General Mitchell?

General MITCHELL. Yes, sir. I do believe you have to make a distinction between the effects on individuals which is probably to be measured in smashed-up equipment, missed days and aircraft accidents, and so forth.

Incidentally, we are striving to enter that very dark area of accidents and misbehavior that might be subtly or directly affected by alcohol and drug abuse, and come out with some figures.

Probably the less glamorous of the studies addresses the business of cohesion and the effects on units. The Walter Reed Army Institute of Research undertook in March of last year, Mr. Chairman, a self-initiated study to determine the effects of drug abuse—and I differentiate drug from alcohol in this instance—but the use of drugs—principally we are talking about marihuana—on tank crews.

While that study is still in process we do have preliminary data to report. We do expect the final report in June of this year. But a couple of interesting things fell out of this. The data, incidentally, was based on the observation of some 65 tanks crews in the European theater.

I will just tick a few of these off for you for your committee's information. Drug use typically occurs in the presence of other crew members, one-half or more at the time and only rarely does it occur alone, an individual member smoking alone.

Rarely do tank commanders use drugs. Now, we are talking about the lowest level of noncommissioned officer, E–5 usually. Those reporting some use are young, single, and do not report use on duty or in the presence of crew members.

There are use-related differences in the perception of tank commanders and crew members– that is the perception that they have for one another. Held in lowest regard are the tank commanders that use drugs. This was true whether rated by using or nonusing crew members, and even though the crews had no direct knowledge that they were using the drugs. In other words, they were held in low esteem for other observable reasons and then the study detected that they were also using drugs.

The more direct knowledge of a crew member's use, the less regard for him by fellow crewmen, regardless of their use or nonuse.

When two crew members had little else in common—and I am talking about residence, or age, or race, or what have you—use or nonuse is a powerful determinant of affiliation within the crew. Users spend time together, nonusers avoid users.

Senator HUMPHREY. Permit me to interrupt you. For my part. I would like to go farther into that tank study. My time is about up. I want to ask General Lukeman to address the same question.

General Lukeman, what is the Marine Corps' conception of the effect on readiness of drug and alcohol abuse?

General LUKEMAN. Sir, I would like to approach that this way: First, I think it is necessary to distinguish between illegal drugs and legal drugs.

To the extent that any Marine uses illegal drugs he knows that action is inseparable from the criminal element that is supplying those drugs. He knows that it represents a type of disrespect for authority, and that concerns me very greatly. Although it is not a tangible effect on readiness, it is an intangible effect.

The second effect is the effect on the individual. I am often asked, "What is wrong with smoking grass?" Well, what is wrong with it is that the individual in fact is whittling away at his life, particularly in his ability to think clearly, which is absolutely integral to the whole business of readiness.

The AMA, the National Academy of Sciences, the National Institute on Drug Abuse all agree on the eventual outcome of repeated use of marihuana and other drugs—dropout personnel, apathy, low frustration level, inability to string thoughts together clearly, difficulty in abstract reasoning, and so forth. And that is absolutely incompatible with readiness. That is why we are so concerned about this problem.

Senator HUMPHREY. Thank you. I think you stated the effects well, the individual effects. The effects on readiness somehow are not being measured, it is not showing up in the measurements being taken.

Unit readiness, we have had testimony this morning, seems not affected and yet we know that individuals are seriously affected. They

exhibit apathy, they exhibit muddled thinking, and surely when they are on duty under those circumstances that has to affect readiness. Yet, that measurement does not seem to be taken.

Senator Exon, we are operating under the 10-minute rule.

Senator EXON. Thank you, Mr. Chairman.

I ask this of the panel, and if any one of you can comment, feel free to do so if you have any information on it. I am looking at the chart, "drug abuse among military personnel."

Do you have any studies to show how that would look if the chart was headed "drug abuse among nonmilitary personnel?"

What I am trying to get at, is the percentage of users we have in the service about the same as those not in the service?

Dr. JOHNS. Yes, sir. We compared the data with the National Institute on Drug Abuse survey of high school seniors, high school students. We find that they are almost identical.

The difference being that the military people live in dormitory style settings away from their homes. If you had that same civilian population there, it would be higher. But if you just take the 18- to 25-year-olds, controlled for sex, marital status, and so forth, they are very close. We run them down, for example, in the past 30-day marihuana-hash use, the military 40 percent, comparable civilian population, 42 percent. In the past 12 months, military 52 percent, civilians 54 percent.

Senator EXON. That was my first question. We then are, at least from this one standard of measure, getting a cross-section of our people in the military, not too different from the civilians. But I suspect that the use might go up away from home for the first time without parental guidance—for whatever it is worth today—it might intensify. I thought the statements that were just made with regard to the tank crew were very interesting.

Now, let me pursue this a little bit further to try and put this in perspective. The 84-percent alcohol figure—what part of that 84 percent do you have any kind of reliable information as to where it is abusive? In other words, you are not saying that there is 84-percent abuse of alcohol in those age groups, are you?

Dr. BEARY. That is correct. One of the pieces of data that came from secondary analysis of that information was that about 30 percent of the population surveyed reported they had work impairment at some point over the past year.

Senator EXON. Thirty percent of the civilian population?

Dr. BEARY. Military.

Senator EXON. Oh, military.

Dr. BEARY. Yes.

Senator EXON. And of the 84 percent, 30 percent of them had some impairment in performing their duties.

Dr. BEARY. Correct. A hangover, possibly; maybe drinking on the job is part of it, and so forth.

Senator EXON. That leads me to the next question that I suggest General Usher might be able to best answer.

What is the general rule in civilian life—like an airline pilot—do they not have some general time and hours when they do not drink before they are going to fly?

General USHER. I believe it is not too different from the military; I think it is 24 hours.

Senator EXON. Twenty-four hours. Do you have any indication that that factor is running about 30 percent? I hope not.

General USHER. No, by no means.

Senator EXON. What do you think—do you have anything on that, General?

General USHER. One piece of data that we do have is where we have any kind of a mishap and what have you affecting the airplane, we test our people on both blood and urine to detect whether there is any drug or alcohol misuse involved there.

Going back several years now, we have had a total of nine aircraft mishaps where there has been alcohol use indicated in those post-accident tests.

On the drug side, since 1974, we have had a total of eight incidents where there has been some drug usage indicated. In a couple of those cases it was, in fact, a misuse of a prescription-type drug. In none of those cases, however, was that the cause of the accident but it was present.

Senator EXON. Backing up for 1 minute, did you say nine alcohol and eight drugs? What percentage of those contributed to the factors of the accidents?

General USHER. What percentage? It was a very, very small percentage of the total number of accidents where there was any drug or alcohol substance present.

Senator EXON. And in those accidents where there was indication from testing, do you have any statistics as to whether or not that was a significant contributor to the accident?

General USHER. In the case of the drugs, I know positively that it was not a causative factor.

Senator EXON. How about the alcohol?

General USHER. In the alcohol, my recollection is that there were none there, either.

Senator EXON. All right. Dr. Beary, you made reference several times to research in this area. We obviously need to get a handle on it. I assume that you are working with the National Institute of Drug Abuse, the National Institute of Health and so forth. Are you coordinating all these activities? They have done some work on this in the past, I am sure.

Dr. BEARY. That is correct. Actually, they have the Federal research mission for drug and alcohol abuse. Unless something has a special military application, we have difficulty supporting it because of the way the statutes are written. So, it is essential that we do continue this cooperation and get NIAAA, et cetera, to assist us.

Senator EXON. Is free information going back and forth and coordination?

Dr. BEARY. Dr. Johns actually sits on the council that coordinates that. Dr. Johns, did you want to comment?

Senator EXON. Could you respond to that question?

Dr. JOHNS. Yes, sir. As a matter of fact, I sit on the NIDA Advisory Council which is meeting today. But I am meeting with Dr. Pollin and three of his people on the 27th of this month to discuss the impairment study we are doing.

They have a clearinghouse of information of their studies. We are one of their major clients, of course. In the past they have done more basic research than we would like. We want more research oriented toward what happens to someone on the job.

Dr. Pollin has indicated his willingness to get people to request research grants and they will support that for us. But I do think we have a complete flow of information.

Senator EXON. Good. Now, gentlemen, let me ask this question: What have the services done to deglamorize the use of alcohol? Can we perhaps down-play or eliminate the so-called happy hours in officers clubs and NCO clubs on bases; have we done that?

General MITCHELL. I could respond to that, Senator Exon. As an example, the commander in chief in Europe, General Kroeseen, shortly after assuming his duties there eliminated the happy hour activity in that theater. He has also recently reduced the ration level for alcohol to soldiers in the theater.

The two-for-one business and all those free prizes of alcohol and so forth that has become so much part of the culture in the club system, all have either been eliminated or dramatically discouraged.

Senator EXON. How about the Air Force, do you know? I do not know if they drink in the Air Force or not. [Laughter.]

General USHER. With regard to the European situation, we are in harness with the Army on that as far as a reduction of the alcohol ration. We have regulations and so forth that require, for instance, that at all social events we have equally nonalcoholic beverages as we do alcoholic beverages.

As a matter of fact, we have a pretty long history in trying to keep this problem within bounds by trying to deglamorize it. We had a task force back in 1976 that took this whole problem apart, looked at all our regulations and the way of operating our clubs and so forth, and put a number of new policies into effect then. I think it has achieved a balance out there in the field where people know that that is not encouraged.

Senator EXON. General Mitchell, I will be back to you. What is an alcohol ration, could you explain that to us?

General MITCHELL. Yes, sir. As a result of the status of forces agreements in many of our overseas theaters highly marketable merchandise was placed under ration control, and one of those items was controlled substance.

In Europe, the ration was recently reduced by order of the commander in chief. But I believe the figure is one-third.

Now, it would still grant an individual bent on intoxication or abuse the opportunity to do so. However, in reducing the ration allowance, General Kroessen has sent a signal to the command, along with the program and everything else that is being done, that he is serious about eliminating the abuse of alcohol.

But it is a status of forces legal international agreement with the countries concerned that alcohol will be rationed.

Senator EXON. You have both mentioned overseas facilities. What have we done to deglamorize, elimination of happy hours, to bringing it down on the bases here in the United States?

General USHER. The policies that I mentioned apply worldwide as far as the Air Force is concerned.

General LUKEMAN. May I respond to that, sir?

Senator EXON. I would be happy to have you, General.

General LUKEMAN. The commandant is presently looking at the Marine Corps policy because the drug is legal, as you know. That is why we hit the illegal drugs first because it is something that our marines can get a handle on and understand.

What we are going to do, I am pretty sure what the commandant is going to start off on is to emphasize that whenever alcohol is consumed it is going to be done in a responsible manner. That there will not be any such thing as beer parties where only alcoholic beverages are available. We are going to emphasize good alternatives where alcohol is not available—and there are plenty of them, of course, most of them ouside, sports and ski trips and that kind of thing.

We are going to try and break the image that being tough necessarily means being hard swearing, hard drinking, and hard brawling.

And of course, just as we did with our drug policy, we are going to emphasize that we just have to set the example and that is exactly what we have been doing, setting the example.

Admiral MULLOY. If I may answer for the Navy, Senator.

Senator EXON. Yes.

Admiral MULLOY. Currently under review by all the second echelon commanders is a control effort similar to our drug program, on reducing alcohol abuse. This is a draft of the Navy's one document, one source for all substance abuse, including treatment, rehabilitation, education, et cetera.

On alcohol abuse there specifically is a chapter on deglamorizing alcohol abuse, citing "happy hour" and some of the other events where nonalcoholic beverages should be provided and encouraged as an alternative. The leadership constrains the abuse of the substance including, as I mentioned, the first-time offense of DWI, would be a 6-month loss of driving privileges on the base. There probably will be some pretty heated discussion between the leader and offender.

I think we are moving in the right direction but, as the general says, we have a legal versus illegal situation. But for my part that also includes that during working hours there is no use of alcohol. That is going to be interesting to see if that gets through because that means the occasional beer at lunch is frowned on. I think we are going in the right direction.

Senator EXON. One last question or observation, Mr. Chairman, probably Dr. Beary or Dr. Johns could respond.

Do you recommend that we try because; you know, we do have idle time, is there any merit to the idea of possibly sanctioning low-alcohol, relatively low-alcohol content beverages such as beer or wine or something like that, as opposed to hard liquor?

I say that in the assumption that that 30 percent of those in that 84-percent category that have caused some problems on duty or about to go on duty probably are caused more by hard liquor than wine or beer. Am I wrong?

Dr. BEARY. Well, actually beer is the most widely consumed beverage. So, I would be reluctant to really endorse one product in the sense that one of the continuing problems in the alcohol abuse area has been getting people who drink a lot of beer to realize that you can become alcohol-dependent from that substance.

I think we would send along an incorrect message if we took that approach. So, I would prefer to focus more on consequences of abuse. Since we know drunk driving costs us many deaths every year, we focus on that very serious problem in people under age 40. We want to get people to think about their alcohol ingestion effort and do what we can to combat the constant media blitz—"Take a pill for every ill." The ads show young people who all look like they make a million dollars a week, that are getting ready to step in a Cadillac, and enjoy all the success of the world for just lighting up a cigarette or having a drink. We have very difficult messages to overcome.

Senator EXON. You do not have any statistics, then, on that 30 percent that I referred to earlier, that yellow chart 84 percent, that you had problems with. You are all commanders and must have some experience.

I am just asking the difficulty that you know of from a personally involved standpoint with people serving under you, are as many of those related to wine and beer as they are to hard liquor?

Dr. JOHNS. My experience is that there are more.

Senator EXON. More?

Dr. JOHNS. Yes, sir. Particularly beer in Europe, where the alcohol content is 12 percent. The German beer, is not like the 3.2 percent we have here. My experience in Europe as a commander is that beer is really the culprit.

Senator EXON. Gentlemen, thank you very much. Thank you, Mr. Chairman.

Senator HUMPHREY. Mr. Secretary, in the 1980 study there was a considerable difference in use between the services. My purpose here is not to disparage any particular branch, but that is an interesting aspect of this study.

Are the preliminary figures of this 1982 study available to you as yet?

Dr. BEARY. No, sir, they are not.

Senator HUMPHREY. Are they still doing field work?

Dr. BEARY. Actually, the collection effort did start.

Dr. JOHNS. The pilot study is being done now. The main collection will be in October–November of this year.

Senator HUMPHREY. Well, in any case, assuming that this difference still exists—let us just focus on this 1980 study, the hard data that we have—what accounts for the difference between the services?

Dr. JOHNS. The vast majority of the variance is accounted for by the demographics. The Air Force comes out much better; they have more females, more married, and they are older. All three of those—and the higher educational level, those four, demographics favor the Air Force. For example, in a secondary analysis between the Marine Corps and the Air Force, where the Marine Corps had something like 47 or 48 percent use of a particular drug, the Air Force had 22 percent. If we control for those four variables, the Air Force would have gone to 40 percent; still different, but not as significant.

I think that the Air Force has had a career field of counselors, they have a very sound program. Their prevention program probably accounts for the rest of the variance.

Senator HUMPHREY. Are you saying that is the difference, the Air Force has had a better program than the other branches?

Dr. JOHNS. From my standpoint it would be bad politics for me to judge. [Laughter.]

I will say this, the Air Force has a very sound program.

Senator HUMPHREY. That leads to another question. Why does DOD allow such latitude to the various services in dealing with this problem? Why don't you choose on the basis of experience which approach works best and mandate that?

Dr. JOHNS. That is a good question, Mr. Chairman. I can add to that equivocation, first of all, we do not believe that we have the right answers. We do not know what works best in some cases. For example, the Air Force has a 4-week residential program for alcoholics, the Navy has 6 weeks.

Now, the Navy has had more publicity as being better. It is very good. But we do not know which is the best.

Senator HUMPHREY. Well, at some point you can make a judgment, can you not, on the basis of results?

I have never known the Department of Defense to be so democratic. [Laughter.]

Dr. JOHNS. Well, the second reason why we do not do it is, Mr. Weinberger and Mr. Carlucci are dead set against what they consider centralized management. They do not like centralized management, neither do I. I support that. I think there are dangers in imposing one way of doing something.

Senator HUMPHREY. I understand. But at the same time, in some of your testimony there was mention of cross-fertilization. If we are not going to mandate a particular approach, then what evidence is there that cross-fertilization is working? By the other branches adopting the elements of certain programs?

General USHER. If I could just make a comment on that. The four of us talk to each other all the time. We come visit each other and find out what the other one is doing. The setting of each of the services is indeed different, as you well know.

We try to make sure we are choosing the best from each other and it works well.

Senator HUMPHREY. Well, can you give an example?

General USHER. Yes; I can give an example. For instance, the Navy just recently has adopted, lock, stock, and barrel, our data system for reporting. I think that is a fair and accurate statement.

Admiral MULLOY. Yes, and their alcohol and drug abuse advisory councils at all levels of command; we instituted that about 4 months ago. I think these are aggressive and effective ways of dealing with the problem. The drug kits are being looked at very closely by them. We are talking to each other.

We have a good program in being, as General Usher said, we will not hesitate to borrow lock, stock, and barrel—when it fits the Navy. It sometimes does not.

Senator HUMPHREY. General Usher said that you are always talking to each other. Now, is that really so—do you have periodic meetings to exchange information?

General USHER. We have had meetings. I mean that more in the generic sense. We all have staffs that deal with this. We have to coordinate. For instance, if Dr. Johns puts out a directive, we all coordinate

on it. We compare notes with each other as to what is the best way to proceed, and so forth. So, our staffs do work very closely together and I would say we probably talk individually to each other once every couple of weeks or so.

Admiral MULLOY. Air Force also trains our drug detection dogs.

General MITCHELL. I would like to confirm Senator, that there is a lot of interchange between services. The Army's rehabilitation center for alcoholics is very much on the Navy pattern, although we believe we have improved on it. It is an extremely effective program, but its genesis was in the Navy program.

I would also like to make the observation, from the survey that you drew your information, that any use of drugs by percentage during the past 12 months is self-admitted by those responding to the survey. Total DOD was 36 percent; Army was 38 percent; Navy was 43; Marine Corps, 47; and Air Force, 23 percent.

Now, while there is a variance and we expect to see a reduction across the board in the 1982 data, there is indeed some similarity there. I do subscribe to Dr. Johns' observations that this is highly impacted by demographics.

Dr. JOHNS. On the coordination, Mr. Chairman, we have about four formal councils or committees that are established to advise me and the services representatives. So we meet on a regular basis.

It includes the Urinalysis Lab Committee. We have a DOD Advisory Council where top people on a working level—usually the colonel level—meet with my staff director, and then periodically I will have lunches hosting the top people. We have our Education and Training Committee that reviews films, TV spots, and the literature that we use.

Senator HUMPHREY. All right. Let us now focus on the intensity of abuse. You showed us a chart that shows a very nice down trend. May I see that again?

How was that information gathered? Is this the only bit of information from that particular study?

Dr. JOHNS. We get regular reports from our urine testing labs and they give us this data. We aggregate it in my office. This is just a way of showing per 10,000 urine samples how it did worldwide. We can give you, by geographic region, these same statistics.

Senator HUMPHREY. All right. How about by service branch—does that same trend still show?

Dr. JOHNS. That is right, and still the Air Force is lowest.

Senator HUMPHREY. Are those branches with a severe problem designing their programs to address this difference in the population? If so, give an example.

Dr. JOHNS. Well, I know we do it by geographical region. For example, Hawaii and Panama have a high cocaine rate. Therefore, the commanders in those areas request that the urine samples going to the lab be checked for cocaine.

Where cocaine is very low in use, a commander may check for amphetamines or heroin. It differs from region to region. I think from the standpoint of the services themselves, it is left up to the individual commander at the particular installation, which he thinks his most significant problem is.

Admiral MULLOY. Mr. Chairman, you mentioned the demographics. For example, the 18- to 25-year-old in the Navy—and the Marine

Corps is the same way—we have a high percentage of our force that is younger and single. We have targeted, since the release of that information, peer-group type movies, TV flicks, and information that is published to appeal to that younger group. Movies where you have a young petty officer encouraging another petty officer to ask for assistance.

So, the answer is yes. From preliminary data, from the portable urinalysis test kit usage, the laboratory confirmation, it is definitely down.

Senator HUMPHREY. So, this is the only information that you derived from these urinalysis tests.

What I am trying to get into here is the intensity of the problem. We know that a certain percentage of people have used, for instance, alcohol or marihuana within the last 12 months or the last 30 days.

But do we have any information on how many times? I mean, there is a big difference between someone who had one drink within the last 30 days and someone who has several drinks a day. Do we have anything on that?

Dr. JOHNS. We have that broken down in detail in our survey that was done in 1980, and we will get it again this year. It tells, for example, 8 to 11 drinks per day average. And it is a large number, a frightening number, that had that. We can tell you that.

Dr. BEARY. We will supply those data tables. I might just use that as a takeoff, though, with stressing the importance of a good information system. Dr. Johns is analyzing at my behest the quality of data, type of data, the ability to answer various questions that you and the other Senators have asked in a timely, updated fashion. We expect to see some improvements, enhancements, on that data system.

Later this summer, I think, the plan for that is going to be complete.

Dr. JOHNS. It is being staffed by the services now. Admiral Mulloy mentioned they patterned theirs after the Air Force which is the best. They have a very good automated system where they can tell you just about anything you want to know.

Dr. BEARY. We are looking at the economic consequences, not only deaths and events such as that.

Admiral MULLOY. Mr. Chairman, by the time we have our management information system on line, the Navy will, hopefully, have a direct correlation with urinalysis tests in addition to some of the other questions. It will also give us a correlation of the urinalysis tests conducted on the same person in an anonymous fashion which we hope will give us the truth about recidivism or repetition. We are gathering raw data now.

Senator HUMPHREY. Well, we had the 1980 full-blown study. We are having another one under way now. There has been nothing in the interim by which you can judge your progress in detail?

Admiral MULLOY. We have been collecting the urine test specimens by the tank cars.

Senator HUMPHREY. They are sitting around in tank cars.

Admiral MULLOY. The data we are talking about, for example 47 percent was mentioned in the DOD survey and also verified by urinalysis in the Navy's survey in January 1981. The latest data has not been fully assessed, but it is running around 23 percent. So, we know we are making progress.

Senator HUMPHREY. Does the urinalysis give you information on the intensity of individual problems or does it just show that person X has used some unknown quantity?

Admiral MULLOY. All that we want to know is about the use of an individual substance is its presence, that is our principle.

Senator HUMPHREY. The measurement of intensity has to be done through interviews; is that correct?

Admiral MULLOY. It is not like alcohol where you can say 0.1 percent blood alcohol content is a measure of intoxication. With the drugs, as I understand it from talking to our chemists, that cannot be done at this time.

Dr. BEARY. You might mention what you mean by "intensity."

Senator HUMPHREY. Frequency of use.

Dr. BEARY. The answer would be, no. Self-reporting methodology is one way to get at it, but it is not as good as direct observations.

A study that just came out within the last couple of months made a big point about the disparity you will see between people reporting their own drinking rates. They all tend to underestimate. Old Joe will say he had a couple of beers, and when you draw blood from him it looks more like he had 10 or 12.

Senator HUMPHREY. Why the 2-year interval between the studies?

Dr. BEARY. The cost is basically the answer. It costs us about $700,000 for each military survey.

Senator HUMPHREY. But in contrast to the cost of drug and alcohol abuse that is not very significant, is it?

Dr. BEARY. Well, I also say that if you end up being able to plot out the data every couple of years on big surveys you will have enough information to work with and in the interim react to that, so that you have a chance to make an intervention and see if it made a difference by the time you measure it again.

Plus, we have some short-term indicators. This data is more prevalent, how much of something happened. The stuff in between on the odd years, if you want to call it that, is incidence data, what things are happening to individual people and then aggregating that you can make short-term corrections as required.

Senator HUMPHREY. I want to announce that Senator Jepsen is equally committed to this issue. We intend to have another hearing next year to examine progress, and particularly to check into this latest study which will be done. What is the completion date on that?

Dr. JOHNS. June. By the time the data is analyzed for the published report, it will be June.

Dr. BEARY. It is June of 1983.

Senator HUMPHREY. Oh, 1983.

Dr. JOHNS. Yes, the data is collected this fall.

Senator HUMPHREY. All right. In any case, the point is that it has been admitted here by some witnesses that the Department of Defense has not been constant in its attention to the problem, and over the years its attention to this problem has risen and fallen. So, we will be having periodic hearings on this.

Now, let me turn to this urinalysis program. I understand that there are great backlogs in the processing of these tests. Is that correct? And if so, what is being done?

Dr. JOHNS. Yes, sir. We had a "glitch" in our program and we started the basic program in a couple of the services before the lab system was geared up to handle it. We did get, as you probably know, a backlog of over 100,000 urine samples.

Senator HUMPHREY. How many days' backing is that?

Dr. JOHNS. Oh, I would say that is probably 45 to 60 days backlog.

Senator HUMPHREY. Is usefulness lost when a commander has to wait that long, when that much time lapses between detection and action being taken?

Dr. JOHNS. Yes, sir.

Senator HUMPHREY. How soon are you going to have that problem fixed?

Dr. JOHNS. I think we have the backlog down now to what, about 7,000?

Admiral MULLOY. That was the way it was when we launched the war, we had the tank cars heading up to the lab. From the report I got last week—the Navy has four laboratories—two are close to target and two of them are down to 20 days and expect to resolve it within a week. So, I am saying by June 1 the Navy on an annual basis will have a capability to run 6.9 million tests annually.

Senator HUMPHREY. What is the DOD target turnaround time, how quickly are they working toward processing these samples?

Dr. JOHNS. Our target is a 48-hour turnaround. When a commander sends it in they are supposed to get an answer back to him within 48 hours.

Senator HUMPHREY. Now, there have been allegations that the subjects of these tests are buying urine samples from someone who does not use drugs and alcohol. What is going on there?

Dr. JOHNS. Well, of course you can substitute a "clean sample" for a "dirty sample" and it would show up negative. Our policy is that the supervisor must observe the taking of the urine sample. If that is followed, then that would not be possible.

Now there are also other techniques of, say, neutralizing a sample. That only works with certain types of technology, it does not work with our final confirmation process that we use in the military which is gas chromatograph.

Senator HUMPHREY. All services are using that?

Dr. JOHNS. All services. That is mandated by the department. That is one place where we do mandate because that technically is what we consider to be absolutely necessary to protect the rights of individuals.

Dr. BEARY. And to follow up on the very important point of protecting the rights of individuals, emphasizing those who are in the judicial system, the chain of custody procedures are very carefully laid out so that we can avoid having the sorts of problems that plagued the District of Columbia police recently when many of their samples got mixed up. Part of using it in court is being able to account for where it was, who had it, and did this urine come out of this person.

So, the services have been reminded that that is an essential part of using this new legal tool for disciplinary reasons.

Admiral MULLOY. The Navy has always emphasized and used chain of custody, Mr. Chairman, for anything related to discharge or discipline, a chain-of-custody procedure, to protect the individual.

Senator HUMPHREY. How soon will this new postal procedure go into effect, can you explain that in a little bit more detail what it comprises? They are not going to open up every package.

Dr. JOHNS. No, sir. In the past, even if you suspected and had probable cause to suspect that drugs were being trafficked through the mail, you had to get a search warrant from a Federal magistrate, a Federal judge. There are none on ships, there are none overseas. So, in effect we just could not do anything about trafficking.

This spring we finally got an agreement between the U.S. Postal Service and Department of Defense which allows military commanders to issue search warrants. When you obtain a search warrant you can use fluoroscopes; you can use sniff dogs; you can use other means to detect. If a person is involved, you can give him a urinalysis test if there is probable cause.

Senator HUMPHREY. How practical is that? I mean, most places are not going to have dogs and fluoroscopes and things like that.

Dr. JOHNS. Oh, yes, sir. We have them and we are increasing by leaps and bounds the use of sniff dogs. We have them on aircraft carriers now. We have fluoroscopes in Europe and places like that.

Senator HUMPHREY. If any commander has reason to suspect, he will be able to cause the opening of packages.

Dr. JOHNS. That is correct.

Senator HUMPHREY. Even if dogs and fluoroscopes are lacking and the commander has reason to suspect?

Dr. JOHNS. Yes, that is correct.

Senator HUMPHREY. What cooperation and exchange of information exists between DOD and the National Institutes on Drug Abuse and Alcoholism?

Dr. JOHNS. Both of them. NIAAA, as I mentioned earlier, I sit on the National Advisory Council for Drug Abuse and Alcohol Abuse. We meet the 27th of this month on alcohol abuse. I meet Loren Archer of NIAAA on alcohol and Bill Pollin frequently. I sit with Bill Pollin at the national level at the White House on drug abuse monthly.

We use their clearinghouse. We send people from my staff and the services. It is really up to us in the Department of Defense, it is there and available to use. I cannot say that all services use it in equal amounts.

Senator HUMPHREY. General Usher, do you produce training films, visual aids, pamphlets and things like that in your efforts?

General USHER. Yes, sir, indeed we do. We have a very comprehensive set of literature that we use for both drug and alcohol abuse education. We have a comprehensive program pursuing that through basic military grants and tech training at each PCS—permanent change of station—point, and also both our NCO and officer professional military education.

Senator HUMPHREY. How do you produce these, where do you get your information?

General USHER. Where do we get our information?

Senator HUMPHREY. Yes.

General USHER. Well, we have a professional group of people, of course, in our drug and alcohol abuse program in the Air Force who have been trained, they know what the sources of this information

are. Specifically, we get information from NIAAA; we get it from our own surveys. I am just informed that the DOD Media Committee tries to cross-fertilize this information.

Senator HUMPHREY. I raise the question because it is an important point. There is a great deal—still to this day—a great deal of inaccurate information and misinformation, particularly about marihuana as well as other drugs and alcohol. Even the National Institute on Drug Abuse until very recently was disseminating information that was at least partly faulty.

There is a whole movement in the case of marihuana that tries to downplay the effects of that drug. That movement, their organization has been fairly successful in getting their pamphlets around and you hear the points argued in those pamphlets, raised all the time by young people who say, "Well, here is this outfit that says it is no worse than lifesavers or something."

So, I want to stress in case you are not aware of it, there is a hell of a lot of faulty information out there, very damaging to what we are trying to do. I hope that all of you will be very careful in selecting what you put in your pamphlets.

General USHER. That is why we have these committees to make sure that we are all speaking from the same data base. This National Science Foundation information has been particularly useful to us. We well realize that we are engaged in an information war, too.

Senator HUMPHREY. Yes. Incidentally, in connection with the next hearing we will be asking you to bring some of these publications. visual aids, with you. We would like to see what you are doing.

To what extent, Dr. Beary, are promotions or assignments for commanders made on the basis of successful drug and alcohol prevention programs? I take it that each commander now a days, down to the smallest unit—correct me if I am wrong—has the same responsibilities. Is that a correct assumption?

Dr. BEARY. That is correct. As far as the individual service policies to reward those activities. I have to defer to the service representatives.

Senator HUMPHREY. If you could make a brief answer, General?

General LUKEMAN. Sir, it is something we have to watch very carefully. We want to make sure that we emphasize the positive part of the program and find out if the leader is doing something special and different that is working. We take that and share it with the other leaders.

We are especially concerned in a situation where a leader has high statistics and a very intractable problem. At this stage in the program he should be given the opportunity to work out that problem. So, we are bouncing the positive against the negative. We are emphasizing the positive.

Senator HUMPHREY. But you do examine that aspect of the commander's performance.

General LUKEMAN. There is comparative examination.

Senator HUMPHREY. Admiral?

Admiral MULLOY. Yes, sir. You mentioned earlier training films, visual aids, pamphlets, et cetera. We have numerous items that have come out since December on drug abuse. TV spots, informed scientific articles. It is a massive media blitz.

Commanders in the field, wherever they have an innovative thing going on, will send it back up for headquarters to look at and circulate

it to other commanders. For example a squadron adopted the term "Stop." There is a T-shirt with an antimarihuana seal on it. That is a big sell item around Pensacola. And talking about "happy hour" and innovation, you could not get in there on a particular Friday in Pensacola unless you were wearing the shirt, which is an interesting combination of ideas.

Whereas before, if somebody put their ship on report for having a heavy rate of drug incidence—today he might even get a medal. The whole emphasis is to reward those that are doing well on these programs and we reward initiative.

Senator HUMPHREY. Good. Your answer is that in the Navy, commanders, right down to the smallest unit where such responsibility lies, are judged on the basis of the performance in this area; is that correct?

Admiral MULLOY. That is part of the assessment of their overall performance.

Senator HUMPHREY. All right, the same question, General Usher.

General USHER. One of the key factors for measuring the effectiveness of commanders is their ability to lead. That very definitely is taken into account in specific detail on our effectiveness reports and so forth. We have made it clear to our commanders that an essential element of successful leadership is their ability to combat this problem. So, it is very definitely being considered.

Senator HUMPHREY. General Mitchell?

General MITCHELL. Yes, sir. This particular type of misbehavior is taken into consideration in the context of leadership. There is no specific entry, there is no specific evaluation point for commanders leading units that may not have drug or alcohol abuse problems.

As General Usher pointed out, units that do not have a problem or have the problem in hand are units that are well led, and that leadership is demonstrated in a whole variety of measurable aspects.

So, I can only tell you, sir, that there is no specific point of measurement on this but it is taken in context.

Senator HUMPHREY. General Mitchell, I would like to ask you at this point to go into some detail on this study of tank crews, give us an overview of that, if you will.

General MITCHELL. Yes, sir.

Senator HUMPHREY. It obviously has implications for all of the services.

General MITCHELL. I believe it does, sir. As I pointed out earlier, this project was undertaken in March of 1981 and we expect the final results in June of this year.

Of some 81 volunteer tank crews that were examined in Europe we have received usable data on some 65 tank crews. I will not repeat all of the preliminary findings that I mentioned a moment ago but I would like to make the observation that as a result of these preliminary findings we believe that cohesion is a significant contributor to unit effectiveness.

I will digress for just a moment and underscore the efforts that have been launched by Secretary Marsh and our Chief of Staff, General Meyer, in an effort to institutionalize cohesion through the regimental system in the U.S. Army.

At the moment we have some 18 or 22 test companies that have been formed for the purpose of keeping soldiers together from train-

ing through entry into the mainline combat duties. Those companies will begin to rotate to overseas areas in October.

I also want to emphasize that we do not believe cohesion needs to be examined per se, but whether we can in fact establish it in our units.

The study that I referred to, however, indicates that drug use and alcohol abuse—it is assumed—impacts unfavorably on cohesion of units. It does this through affecting soldiers' perceptions of one another, diminishing mutual respect between leaders and led; and furthermore, the results would suggest that it isolates soldiers, placing those who use and those who do not use in opposing camps.

When units lack the stability that we recognize in cohesive units, soldiers may have very few other bases for relating to one another, other than drug use. So, the effort is to replace drug use with alternatives that cause bonding in the good sense of the word.

The entire aspect of the Army's new manning system which incorporates the cohort companies in the regimental system for the late 1980's and 1990's is going to be a function of the evidence being provided by studies like this.

I regret that I am unable to provide you definitive data at this point in time and I am not sure in measuring such a complex social phenomenon that we will end up with a whole laundry list of definitive data. But we believe the study will be worthwhile. It is confirming for us things that we only suspected before.

Senator HUMPHREY. You mentioned that users and nonusers tend to segregate themselves into camps. Can you say, from your current information, that drug users object to serving with nonusers?

General MITCHELL. That would be my conclusion, yes, sir.

Senator HUMPHREY. What is the balance of peer pressure, are the nonusers able to prevail or is it the other way around?

General MITCHELL. I hope to be able to report that the nonusers have prevailed, sir. Our efforts have got to be targeted on the peer pressure motivation here in order to particularly make the junior entering soldier recognize that he is not going to be part of a main line Army if he is abusing alcohol or using drugs.

Clearly, as Admiral Malloy pointed out, the bottom line, most dramatically affected element in all of this is going to be peer pressure. So, we have to provide the environment in which peer pressure can take over and therefore diminish, if not rid us, of the people that use drugs.

As you know, Mr. Chairman, the Army is enjoying enormous success now in accessing high school diploma graduates, upper mental category individuals, and we have applied similar criteria for the retention of soldiers. We strongly believe—and we hope to be able to show you measurable results next year—that this type of soldier being accessed and retained is going to be a soldier who will assist us in ridding the Army of the use of illicit drugs.

Senator HUMPHREY. Very good. We will continue here for a few more minutes.

In that vein, Mr. Secretary, have the branches altered their recruitment criteria in any way to try to reduce the exposure to the drug and alcohol abuse prone population?

Dr. BEARY. Yes they have, Mr. Chairman. For instance, the Navy has a program for doing some urine testing at the examining station.

Admiral Mulloy may want to say a word about that.

Admiral MULLOY. Forty-eight hours after a recruit comes into the recruit training center (RTC), every one, 100 percent, are tested. We are doing 100 percent testing of all officers and enlisted accessions.

Senator HUMPHREY. Senator Jepsen asked me to put this question. Mr. Secretary, the chief judge of the Court of Military Appeals has expressed concern over the increased number of drug cases involving junior officers. Have you noticed any increase, and if so what increases?

Dr. BEARY. Dr. Johns, do you have any prevalence figures on that? A rate of increase is difficult for me to comment on in that the 1980 figure was our first good feel for the data. To say whether the slope is going up or down is difficult.

There have been some officers, certainly, detected with the new technology we have for detecting cannabis. They have been dealt with very harshly with the point being made that the expectations are higher for officers than for others. By making an example of some of these people one person can tell another and thus create the environment where we can count on our NCO's and officers to be leading and not participating in this. But I do not have a sense that it is a widespread problem of the officers corps.

Admiral MULLOY. Mr. Chairman, part of this might be due to the use of portable urine testing kits, random searches, and overall increased detection efforts. An officer cannot lie on urinalysis testing. What the Navy surveys have reflected is that the incidents have gone down due to increased efforts in detection and deterrence.

Mr. PRINCIPI. We have been speaking in terms of drug abuse on the part of the soldier, the sailor, and the airman. Now we have indications that it is more widespread and affects the junior officer corps. What ramifications does that hold?

Dr. JOHNS. I can address that. I think strictly on marihuana you will probably find some junior officers who are in that age group now where it is more prevalent. I believe it will probably show an increase. Now that we can detect this in urinalysis, it will show an increase in the amount of court martials and punitive actions because the services have taken a no-tolerance view toward it.

I think the reason they have taken that is—to answer your question—we cannot put up with leaders who set the example who are using illegal drugs. I think that is one area where we just have to say, "If it is important to you, you had better not choose the military as a profession because we are going to zap you." I think those are the amplications and, I think, rightly so. We are just saying, "No way."

Admiral MULLOY. I am sure you are aware that Admiral Hayward set policy which requires, in addition to the law, for officers, "One time—out." We suggested to the chief petty officers, "Two times—out," and the CPO's said, "No. One time—out." That conveys the notion. And with the portable urine testing kits and the unit sweeps, they are now accurately and scientifically detected, the word is getting out.

Senator HUMPHREY. Do you have any yardsticks to show the level of resources devoted to combating these problems?

Dr. JOHNS. Yes, sir. We have 4,100 people full time engaged in this, and a budget this year of $126 million. Next year, in fiscal year 1983, it will be $142 million.

Senator HUMPHREY. That is for all the services?

Dr. JOHNS. For the Department of Defense, the four services and a minuscule amount for the Office of the Secretary of Defense specifically.

Senator HUMPHREY. Very well. Thank you very much for your time and your testimony. I congratulate you on the progress you have made. We will be eagerly waiting to see the report next year.

Dr. BEARY. Thank you, sir.

Senator HUMPHREY. Senator Jepsen has some questions to be answered for the hearing record.

[Questions with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR ROGER W. JEPSEN

EFFECT OF ALCOHOL AND DRUG ABUSE ON MILITARY READINESS

Senator JEPSEN. Dr. Beary and other panel members, what effect does alcohol and drug abuse have on military readiness? What studies has DOD conducted to measure the extent of the effect of substance abuse on preparedness?

Dr. BEARY. Senator Jepsen, that is a very difficult question to answer with any precision. As I indicated in my testimony, common sense tells us that alcohol and drug abuse has some negative impact on readiness. However, the effect has been impossible to define and quantify. It is clear that alcohol and drug abuse increases the cost involved in staying ready—by at least the approximately $140 million per year we spend on prevention, treatment, and rehabilitation programs. When you factor in accidents, lost productivity, attrition, and similar factors the costs obviously increase substantially.

When we talk to commanders, they acknowledge that alcohol and drug abuse is a factor which makes it more difficult to stay ready; however, they maintain that they are combat ready. Their contention is supported by our no-notice inspections, our exercises, and our operational records. We are experiencing some of the best safety and operational records in our history. A common sense interpretation of this phenomenon is that good soldiers are compensating by picking up the workload of the drug abusers.

We have tried a variety of approaches to measure the effect of substance abuse on preparedness. The attached "Highlights from the Worldwide Survey of Nonmedical Drug Use and Alcohol Use Among Military Personnel: 1980," which I would like to insert for the record, details a whole range of adverse personal and institutional effects. (See p. 55.) However, it does not precisely answer the direct effect on military readiness.

To isolate specific effects, we have been conducting research projects since 1978—all with limited results.

In July 1978, the Deputy Secretary of Defense initiated a number of actions to revitalize and improve the DOD substance abuse prevention program, one of which was the conduct of research concerning the impact of substance abuse on military readiness. The Army, which had some research expertise related to this subject in the Division of Neuropsychiatry, Walter Reed Army Institute for Research (WRAIR), was subsequently designated as the "DOD Executive Agent" for this initiative. However, no additional funds and manpower were available within a highly constrained R. & D. budget.

WRAIR was tasked to develop a comprehensive plan for conducting research on substance abuse effects on individual and unit performance. The Army Medical R. & D. Command internally reprogrammed funds to support the effort at a core level of about $500-600K per year within the Military Psychiatry Research Budget. An $8 million, five-year research plan was drafted but was clearly unsupportable by DOD. So the Army was relegated to pursuing a limited effort within existing resources.

In fiscal year 1980 the House Appropriations Committee again reduced funding for Military Psychiatry Research which led to a 50 percent cut for substance abuse research—from $500–600K to about $300K. Further budget reductions were sustained in fiscal year 1981.

In this resource starved environment, the Army has been able to accomplish a few projects. The first involved a comprehensive review of scientific literature

on drug and alcohol effects on individual performance. The project was concluded in December 1979 with the recommendation that further research in this area would be costly and of questionable value. Isolating the effects of different substances on the performance of discrete tasks in various military occupational specialties without the use of human subjects was impossible. There is also no laboratory technique for efficiently simultaing a wide range of tasks from which valid and generalized findings can be made.

Research on substance abuse effects on combat readiness has proceeded on two tracks. A computer simulation analysis of hypothetical combat performance degradation was completed in April 1980. This abstract analysis, which assumed varying levels of abuses for personnel less than 25 years old, in a "short war" scenario, indicated no serious degradation of combat capabilities except for the fire direction elements of artillery units. Unit force structures at company levels in the Army appear to be sufficiently flexible to permit reconstituting combat capabilities after sustaining drug or alcohol abuse and other combat casualties as high as 30 percent. A major limitation of the study is that it does not include an analysis of the human or sociological dynamics of substance abuse and troops in combat.

The second thrust of this research is a project to examine the effects of drug and alcohol abuse on the cohesion of tank crews. This project was started in March 1981 in USAREUR. Data analysis is in progress and we expect results later this summer. The project is designed to produce a practical methodology for assessing small group cohesion and relating patterns of substance abuse to cohesion and group performance.

A related project, which was separately sponsored by the U.S. Army Institute for the Behavioral and Social Sciences, was designed to evaluate the relationships between unit command climate and combat readiness measures. The project involved four waves of data which were collected in 55 battalions between May 1978 and November 1979. Results indicated that substance abuse is one of 21 measures consistently used by senior commanders to assess unit effectiveness and that the subjective judgment of those commanders is the best source for evaluating unit readiness. To date, surveys and interviews with commanders identify substance abuse as a problem but not to the extent that it affects unit combat readiness. The scientific correlation of drug abuse with quantitative and qualiative measures of command climate and readiness cannot be fully ascertained from this single project since it was designed to focus on the broader aspects of command climate.

We have also considered enlisting the scientific expertise of the National Academy of Science to help examine the problem. Our preliminary contact with the Academy revealed that it would take about $400K for a 14 month level of effort to begin identifying the most relevant research methodologies for studying this complex problem. We have no estimate for how long thereafter it would take to conduct any of the recommended studies. The cost is prohibitive within the current DOD R&D budget.

We are presently putting together an in-house test protocol to secure direct observations of people in sensitive duties during their actual operations. We are working with the National Institute on Drug Abuse on this study. It will take place later this year. We expect it to answer a significant number of questions that we have about impact on readiness. However, we will still not have a final scientific answer. A concealed behavior like alcohol and drug abuse is inherently difficult to identify and measure. Measurement of its precise impact on readiness is even more difficult. We plan to continue to pursue the issue, but obtaining a precise answer will not be easy.

In the absence of "hard" data on the impact on readiness from alcohol and drug abuse, we rely heavily on the judgment of our front-line leaders and the "proof of the pudding," actual unit performance. As the Survey and Investigations Team from the House Appropriations Committee recently found, these two indicators are the best we have available.

ARMY

General MITCHELL. The Army's leadership recognizes that drug and alcohol abuse is a serious problem that impacts on people and affects readiness. Costs related to attrition, treatment and rehabilitation costs, law enforcement, and legal actions, and other related activities drain monies that could be better used to enhance combat readiness. The presence of substance abusers diverts

leaders from training, maintenance, and other responsibilities which directly influence combat readiness.

In 1978 the Army was designated as executive agent for conducting indepth research on the precise impact of drug abuse on duty performance and combat readiness. Initial research conducted by the Walter Reed Institute for Research (WRAIR) for the Department of Defense, proved to be fruitless and costly. Congress has subsequently expressed reservations about funding additional studies.

A comprehensive review of scientific literature on drug and alcohol abuse effects on individuals was also completed in December 1979. WRAIR concluded that further research in the area would be prohibitive in terms of costs in trying to isolate the effects of different substances on the performance of direct tasks in various military occupational specialties without the use of human subjects.

In the absence of proven methodology to isolate the effects of substance abuse, the assessment of readiness impact is accomplished within the parameters of the readiness reporting system. Readiness reporting is both an objective and subjective evaluation process as to the unit's capability to perform its mission in support operational requirements. While the specific components of readiness are, quantified for reporting purposes, individual performance and teamwork are readily discernible and habitually observed by commanders. Ultimately, the commander evaluation is a function of quantifiable status and subjective judgment of his soldiers' exhibited individual and collective work performance.

An Army survey conducted in February 1981 included 13 personnel related issues—ranging from racial harmony to noncommissioned officer shortages and personnel turn-over—in addition to the three questions dealing with drug abuse. Analysis of commanders responses from that survey show that drug and alcohol abuse ranked relatively low in terms of impact of readiness.

The staff of the Residential Treatment Facility (RTF) at William Beaumont Army Medical Center, El Paso, Texas, will conduct a one-year follow-up survey of patients who have been treated at that facility. The survey is designed to determine how successful the treatment has been through evaluation of the individual's performance. A similar survey will be conducted by the RTF located in Seoul, Korea, at the 121st Evacuation Hospital. Both surveys are in-house efforts, with costs being absorbed within existing budgets.

NAVY

Admiral MULLOY. Without a doubt abuse of alcohol or drugs effects an individual's ability to perform specific tasks. To date no ship or squadron of aircraft have reported non-operational due to drug or alcohol abuse. Navy's Management Information System for the Drug and Alcohol Program, when fully on-line, should be able to correlate the various factors and provide us with a meaningful and accurate assessment of the situation. Our aggressive engagement of the substance abuse problem is already making significant inroads and will hopefully eliminate this threat to readiness, good order and discipline. The Fleet Commanders in Chief report a definite decline in use since our "War on Drugs" started.

Senator JEPSEN. The results of your 1980 worldwide survey indicate that alcohol and marihuana are the primary drugs of abuse. What are you doing to reduce the use of these drugs?

Dr. BEARY. As Dr. Johns mentioned in his testimony, two significant developments have recently occurred that will enable us to reduce the level of cannabis use. First, we can now detect cannabis through urinalysis. Second, we can take disciplinary actions based on a positive urinalysis. One of the major reasons for continued high levels of cannabis use among our troops has been the inability to detect its use. Now that we have solved this problem, I think you are going to see some positive results in significantly reducing cannabis use.

The abuse of alcohol has remained a chronic problem. If we are to be credible in our efforts to reduce marihuana use, we must take a strong stand against the abuse of alcohol. I have directed my staff to prepare a plan to reduce the incidence of drunk driving. I expect to staff a draft proposal with the Services in early June. The proposal will feature a three pronged approach—stiff penalties, education and impaired driver identification. I believe this much needed initiative against one of the leading killers of young people will significantly reduce the abuse of alcohol in the Department.

General MITCHELL. There are two specific areas I would like to address.

First, detection and control measures employed by the Army include the use of Drug Suppression Teams, detector dogs, health and welfare inspections, and biochemical testing. These activities are aimed at eliminating the supply of illegal drugs available to Army personnel and to identify and apprehend individuals who illegally possess, use, or traffic in drugs.

The Drug Suppression Teams are the primary tool used by Army law enforcement to combat the drug threat facing the Army. The Army employs 73 Drug Suppression Teams, staffed with over 352 military police investigators and criminal Investigation Command special agents. These teams are responsible for the suppression of illicit drug trafficking directed toward Army personnel worldwide.

Law enforcement activities have begun utilizing the small breed narcotic detection dog which allows detection in areas that were previously inaccessible to the large-breed dogs.

Second, are two new innovations in biochemical testing. First, a pilot test of breathalyzer machines that detect the presence of alcohol for use in rehabilitation and education, in addition to their current use in law enforcement.

Second, a pilot test of portable urinalysis kits to give quick answers on specimen negatives and identify specimen positives which are then forwarded to the urinalysis laboratories for confirmation.

HIGHLIGHTS FROM THE WORLDWIDE SURVEY OF NONMEDICAL DRUG USE AND ALCOHOL USE AMONG MILITARY PERSONNEL: 1980

by:

Marvin R. Burt, D.P.A.
Mark M. Biegel, M.A.

with the assistance of:

Yukiko Carnes, M.A.
Edward C. Farley, M.S.W.

The views and conclusions contained in this document are those of the authors and should not be interpreted as necessarily representing the official policies, either expressed or implied, of the Department of Defense or the U.S. Government.

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BURT ASSOCIATES, INCORPORATED
4340 East West Highway
Suite 506
Bethesda, Maryland 20014

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Section 1: INTRODUCTION

This report is intended primarily to provide highlights of the results of a 1980 survey of nonmedical drug use and alcohol use among military personnel. Estimates are provided of the prevalence and consequences of nonmedical drug use and alcohol use among the active duty military population. The prevalence rates are compared with those obtained on a comparable civilian subpopulation. The findings are reported in statistical terms and can serve as an empirical basis for the formulation of policies and programs for the prevention and treatment of drug and alcohol abuse in the Military Services. More detailed findings are presented in the main report.[1]

The survey is focused on nonmedical use of nine types of drugs and on use of three types of alcoholic beverages. Samples of 81 installations, worldwide, and 19,582 active duty personnel at these installations were randomly selected. The selection was made from all personnel in pay grades E1 through O6 in each of the four Services. Ninety-three percent of the eligible sample completed the multiple choice format questionnaire in group sessions proctored solely by the study team of Burt Associates, Incorporated. Additional details on the sampling design population characteristics, number of respondents, and confidence intervals are summarized in the Technical Note at the end of this report.

In Section 2, summary findings are presented on current (past 30 days) and annual (past 12 months) nonmedical use of drugs and on the physical, social and work-related consequences of drug use. Similar information on alcohol use is highlighted in Section 3. The data are often presented for the total respondent group, by Service, and pay grade group.

Comparisons between prevalence data in this survey and the most recent survey of the civilian population are summarized in Section 4.

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[1] Marvin R. Burt and Mark M. Biegel, Worldwide Survey of Nonmedical Drug Use and Alcohol Use Among Military Personnel: 1980 (Bethesda, Maryland: Burt Associates, Incorporated), 1980.

Section 2: NONMEDICAL DRUG USE - PREVALENCE AND CONSEQUENCES AMONG MILITARY PERSONNEL

"Nonmedical drug use" is defined, for the purpose of this survey, as the use of drugs for nonmedical purposes, that is, for highs, for thrills, to relax, to give insight, or for pleasure. The nonmedical use of drugs is common throughout broad segments of American society. Concern has been expressed about the extent to which military personnel engage in nonmedical drug use and the consequence of such use in terms of their individual well-being and their work performance. The survey results address these concerns.

Prevalence

The nine drug types used for prevalence estimates are listed below, together with verbatim examples from the questionnaire:

DRUG	EXAMPLE
Marijuana	"Pot," "Grass"
Hashish	"Hash"
PCP	"Angel Dust"
Other Hallucinogens	LSD, Mescaline, Peyote, STP, DOM, DMT, Psilocybin
Cocaine	"Coke," "Snow"
Amphetamines	Benzedrine, "Bennies," Methadrine, Dexedrine, "Speed"
Other Uppers	Preludin, Ritalin, Sandrex
Tranquilizers	Valium, Librium, Miltown
Barbiturates	Seconal (reds), Nembutal (yellows), Amytal (blues)
Other Downers	Quaalude (Sopors), Optimil, Doriden, Placidyl, Methaqualone
Heroin	"Smack," "Scag," "Horse"
Other Opiates	Morphine, Opium, Demerol, Codeine, Methadone

Table 1 shows that over one-fourth (27 percent) of the military personnel reported they had used some type of drug or drugs nonmedically in the past 30 days; over one-third (36 percent) reported such use within the past 12 months. The figures for marijuana or hashish use are much the same as those for "any drug use," indicating that nearly all users of nonmedical drugs used at least marijuana or hashish. None of the other eight drug types (listed in rank order of prevalence of use) approaches marijuana or hashish in popularity.

The percentages of military personnel reporting use of each drug weekly or more frequently than weekly during the past 30 days are shown in Table 2. Clearly, there are substantially fewer regular users (i.e., persons using weekly or more frequently) than occasional users. For example, while 36 percent reported use of marijuana or hashish during the past year, 27 percent reported use during the past 30 days and 19 percent reported use at least once a week during the past 30 days. This pattern generally holds for all the drug types (except that there is no difference between nonmedical use of barbiturates during the past 30 days and at least once a week). Thus, it can be concluded that the overwhelming majority of nonmedical drug use in the military is occasional or experimental in nature.

Prevalence rates vary by Service and region. It has not been established to what extent some or all of these variations are attributable to the different composition of the personnel in the four Services.[1]

Nonmedical drug use is limited primarily to personnel in the E1-E5 pay grade group (Tables 3 and 4), a phenomenon that may be attributable to the comparatively younger age of junior enlisted personnel. Patterns of use by drug and Service among E1-E5's are similar to those noted for the total respondent group.

Tables 5 through 13 depict the current prevalence for each of the nine drug types by Service, pay grade group, and geographical region. In general, current prevalence rates for each drug type are as high or higher in CONUS than in other regions.

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[1] Drug prevalence correlates strongly with lower adult age, being unmarried, being male, and lower educational attainment. To the extent that a Service has a higher proportion of personnel with these characteristics, it can be expected to have a higher prevalence of nonmedical drug use.

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TABLE 1

POPULATION USING EACH DRUG

(PERCENTAGE)

DRUG TYPE/ USE PERIOD	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ANY DRUG USE					
PAST 30 DAYS	27	29	33	37	14
PAST 12 MONTHS	36	38	43	47	23
MARIJUANA/HASHISH					
PAST 30 DAYS	26	28	32	36	14
PAST 12 MONTHS	35	37	42	47	22
AMPHETAMINES OR OTHER UPPERS					
PAST 30 DAYS	6	6	10	8	3
PAST 12 MONTHS	13	12	19	19	6
COCAINE					
PAST 30 DAYS	4	4	7	8	1
PAST 12 MONTHS	11	10	17	19	5
HALLUCINOGENS (OTHER THAN PCP)					
PAST 30 DAYS	3	2	5	7	1
PAST 12 MONTHS	8	7	12	15	3
TRANQUILIZERS					
PAST 30 DAYS	2	2	3	2	1
PAST 12 MONTHS	6	5	9	7	2
BARBITURATES OR OTHER DOWNERS					
PAST 30 DAYS	2	3	3	3	1
PAST 12 MONTHS	6	6	8	9	3
OPIATES (OTHER THAN HEROIN)					
PAST 30 DAYS	1	2	2	2	+
PAST 12 MONTHS	4	4	5	6	1
PCP					
PAST 30 DAYS	1	1	1	3	+
PAST 12 MONTHS	4	4	5	10	1
HEROIN					
PAST 30 DAYS	1	1	1	+	+
PAST 12 MONTHS	2	3	1	1	+

+ LESS THAN HALF OF ONE PERCENT.

TABLE 2

FREQUENCY OF USING DRUG NONMEDICALLY AT LEAST ONCE A WEEK DURING THE PAST 30 DAYS--TOTAL DOD

(PERCENTAGE OF POPULATION)

DRUG TYPES	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
MARIJUANA/HASHISH	19	23	24	29	10
AMPHETAMINES OR OTHER UPPERS	3	3	5	4	1
COCAINE	2	1	3	3	+
BARBITURATES OR OTHER DOWNERS	1	2	1	1	+
HALLUCINOGENS (OTHER THAN PCP)	1	1	2	2	+
TRANQUILIZERS	1	1	1	2	1
OPIATES (OTHER THAN HEROIN)	+	1	1	1	+
PCP	+	+	+	1	+
HEROIN	+	+	+	+	+

+ LESS THAN HALF OF ONE PERCENT.

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TABLE 3

POPULATION USING EACH DRUG--BY PAY GRADE GROUP

(PERCENTAGE)

DRUG TYPE/ USE PERIOD	TOTAL DOD	PAY GRADES				
		E1-E5	E6-E9	W1-W4	01-03	04-06
ANY DRUG USE						
PAST 30 DAYS	27	38	5	3	4	1
PAST 12 MONTHS	36	50	9	4	9	2
MARIJUANA/HASHISH						
PAST 30 DAYS	26	37	4	3	3	1
PAST 12 MONTHS	35	49	9	3	8	1
AMPHETAMINES OR OTHER UPPERS						
PAST 30 DAYS	6	9	1	0	+	+
PAST 12 MONTHS	13	19	2	0	1	+
COCAINE						
PAST 30 DAYS	4	7	+	0	+	0
PAST 12 MONTHS	11	17	1	2	+	+
HALLUCINOGENS (OTHER THAN PCP)						
PAST 30 DAYS	3	5	+	0	+	0
PAST 12 MONTHS	8	12	1	0	+	+
TRANQUILIZERS						
PAST 30 DAYS	2	3	+	0	+	0
PAST 12 MONTHS	6	8	1	+	1	+
BARBITURATES OR OTHER DOWNERS						
PAST 30 DAYS	2	3	+	0	+	0
PAST 12 MONTHS	6	8	1	0	1	0
OPIATES (OTHER THAN HEROIN)						
PAST 30 DAYS	1	2	+	0	+	0
PAST 12 MONTHS	4	5	+	0	+	+
PCP						
PAST 30 DAYS	1	1	+	0	0	0
PAST 12 MONTHS	4	6	+	0	+	0
HEROIN						
PAST 30 DAYS	1	1	+	0	0	0
PAST 12 MONTHS	2	2	+	0	0	+

+ LESS THAN HALF OF ONE PERCENT.

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TABLE 4

POPULATION OF E1-E5'S USING EACH DRUG BY SERVICE

(PERCENTAGE)

DRUG TYPE/ USE PERIOD	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ANY DRUG USE					
PAST 30 DAYS	38	41	48	48	21
PAST 12 MONTHS	50	53	59	61	33
MARIJUANA/HASHISH					
PAST 30 DAYS	37	40	47	47	20
PAST 12 MONTHS	49	52	58	60	32
AMPHETAMINES OR OTHER UPPERS					
PAST 30 DAYS	9	8	15	10	4
PAST 12 MONTHS	19	17	28	25	9
COCAINE					
PAST 30 DAYS	7	6	11	10	2
PAST 12 MONTHS	17	15	25	26	8
HALLUCINOGENS (OTHER THAN PCP)					
PAST 30 DAYS	5	3	7	10	2
PAST 12 MONTHS	12	10	18	21	5
TRANQUILIZERS					
PAST 30 DAYS	3	3	4	3	1
PAST 12 MONTHS	8	8	13	9	3
BARBITURATES OR OTHER DOWNERS					
PAST 30 DAYS	3	4	5	4	1
PAST 12 MONTHS	8	8	12	11	4
OPIATES (OTHER THAN HEROIN)					
PAST 30 DAYS	2	2	2	2	1
PAST 12 MONTHS	5	6	7	7	2
PCP					
PAST 30 DAYS	1	2	2	4	+
PAST 12 MONTHS	6	6	7	13	1
HEROIN					
PAST 30 DAYS	1	2	1	+	+
PAST 12 MONTHS	2	4	2	1	1

+ LESS THAN HALF OF ONE PERCENT.

TABLE 5

POPULATION USING MARIJUANA/HASHISH
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	27	29	34	39	14
E1-E5	39	41	48	51	21
E6-E9	5	6	6	5	3
O1-O3	3	5	2	6	2
O4-O6	1	0	0	0	1
EUROPE					
TOTAL	23	28	18	*	13
E1-E5	33	39	27	*	20
E6-E9	2	3	3	*	1
O1-O3	3	6	0	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	21	20	24	28	14
E1-E5	32	36	42	36	19
E6-E9	4	3	5	5	3
O1-O3	4	5	6	-	4
O4-O6	2	0	-	-	4
OTHER LOCATIONS					
TOTAL	22	29	21	*	13
E1-E5	32	38	33	*	19
E6-E9	4	8	3	*	0
O1-O3	4	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	26	28	32	36	14
E1-E5	37	40	47	47	20
E6-E9	4	5	6	5	2
W1-W4	3	5	0	-	*
O1-O3	3	5	2	5	2
O4-O6	1	0	0	2	1

\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 6

POPULATION USING PCP
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1	1	1	3	+
E1-E5	2	2	2	4	+
E6-E9	+	+	+	0	0
O1-O3	0	0	0	0	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	1	1	+	*	+
E1-E5	1	1	+	*	+
E6-E9	0	0	0	*	0
O1-O3	0	0	0	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	1	1	1	1	0
E1-E5	1	1	1	2	0
E6-E9	0	0	0	0	0
O1-O3	0	0	0	-	0
O4-O6	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	+	+	0	*	0
E1-E5	0	0	0	*	0
E6-E9	+	1	0	*	0
O1-O3	0	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	1	1	1	3	+
E1-E5	1	2	2	4	+
E6-E9	+	+	+	0	0
W1-W4	0	0	0	-	0
O1-O3	0	0	0	0	0
O4-O6	0	0	0	0	0

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 7

POPULATION USING HALLUCINOGENS (OTHER THAN PCP)
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	4	2	6	8	1
E1-E5	5	4	9	11	2
E6-E9	+	0	1	0	0
O1-O3	+	0	0	1	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	2	2	+	*	1
E1-E5	2	3	+	*	1
E6-E9	0	0	0	*	0
O1-O3	0	0	0	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	2	2	2	5	1
E1-E5	4	3	5	7	1
E6-E9	+	0	0	1	0
O1-O3	+	0	1	-	0
O4-O6	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	1	3	1	*	0
E1-E5	2	4	1	*	0
E6-E9	0	0	0	*	0
O1-O3	0	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	3	2	5	7	1
E1-E5	5	3	7	10	2
E6-E9	+	0	1	+	0
W1-W4	0	0	0	-	*
O1-O3	+	0	+	1	0
O4-O6	0	0	0	0	0

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 8

POPULATION USING COCAINE
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	5	4	8	8	1
E1-E5	7	6	11	11	2
E6-E9	+	+	1	0	0
O1-O3	+	0	+	1	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	3	4	+	*	2
E1-E5	4	5	1	*	2
E6-E9	+	+	0	*	0
O1-O3	0	0	0	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	4	3	6	6	+
E1-E5	6	5	10	8	+
E6-E9	1	1	1	0	1
O1-O3	0	0	0	-	0
O4-O6	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	4	6	2	*	2
E1-E5	6	8	4	*	3
E6-E9	+	1	0	*	0
O1-O3	0	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	4	4	7	8	1
E1-E5	7	6	11	10	2
E6-E9	+	+	1	0	+
W1-W4	0	0	0	-	*
O1-O3	+	0	+	1	0
O4-O6	0	0	0	0	0

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 9

POPULATION USING AMPHETAMINES OR OTHER UPPERS
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	7	6	12	9	3
E1-E5	10	8	17	11	4
E6-E9	1	1	1	1	1
O1-O3	0	0	0	0	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	5	6	3	*	2
E1-E5	7	9	5	*	3
E6-E9	1	1	0	*	0
O1-O3	+	0	3	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	4	3	4	4	3
E1-E5	6	6	7	6	4
E6-E9	+	0	0	1	1
O1-O3	1	2	1	-	1
O4-O6	+	0	-	-	2
OTHER LOCATIONS					
TOTAL	4	6	4	*	2
E1-E5	6	7	7	*	2
E6-E9	+	1	0	*	0
O1-O3	0	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	6	6	10	8	3
E1-E5	9	8	15	10	4
E6-E9	1	1	1	1	1
W1-W4	0	0	0	-	*
O1-O3	+	+	+	0	+
O4-O6	+	0	0	0	+

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 10

POPULATION USING TRANQUILIZERS
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	2	2	3	2	1
E1-E5	3	3	4	3	1
E6-E9	1	+	2	0	0
O1-O3	+	+	0	0	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	2	3	3	*	1
E1-E5	3	4	5	*	2
E6-E9	+	0	0	*	1
O1-O3	0	0	0	*	0
O4-O6	+	-	0	*	1
PACIFIC					
TOTAL	2	2	2	3	1
E1-E5	3	4	4	3	1
E6-E9	+	0	0	1	0
O1-O3	0	0	0	-	0
O4-O6	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	2	3	3	*	0
E1-E5	3	4	4	*	0
E6-E9	1	2	0	*	0
O1-O3	3	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	2	2	3	2	1
E1-E5	3	3	4	3	1
E6-E9	+	+	1	+	+
W1-W4	0	0	0	-	*
O1-O3	+	+	+	0	0
O4-O6	0	0	0	0	0

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 11

POPULATION USING BARBITURATES OR OTHER DOWNERS
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	2	2	3	3	1
E1-E5	3	3	5	4	1
E6-E9	+	0	1	0	0
O1-O3	1	1	0	1	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	2	3	2	+	1
E1-E5	3	4	2	+	1
E6-E9	0	0	0	+	0
O1-O3	0	0	0	+	0
O4-O6	0	-	0	+	0
PACIFIC					
TOTAL	2	2	2	3	1
E1-E5	3	4	4	4	1
E6-E9	0	0	0	0	0
O1-O3	0	0	0	-	0
O4-O6	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	2	2	3	+	1
E1-E5	3	3	6	+	1
E6-E9	0	0	0	+	0
O1-O3	0	-	-	+	-
O4-O6	0	-	-	+	-
TOTAL WORLDWIDE					
TOTAL	2	3	3	3	1
E1-E5	3	4	5	4	1
E6-E9	+	0	1	0	0
W1-W4	0	0	0	-	+
O1-O3	+	1	0	1	0
O4-O6	0	0	0	0	0

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
\+ NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 12

POPULATION USING HEROIN
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1	1	1	+	+
E1-E5	1	1	1	+	+
E6-E9	+	0	+	0	0
O1-O3	0	0	0	0	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	2	3	0	*	1
E1-E5	3	4	0	*	1
E6-E9	0	0	0	*	0
O1-O3	0	0	0	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	+	1	1	+	+
E1-E5	1	1	1	+	+
E6-E9	0	0	0	0	0
O1-O3	0	0	0	-	0
O4-O6	0	0	0	-	0
OTHER LOCATIONS					
TOTAL	+	0	0	*	+
E1-E5	+	0	0	*	+
E6-E9	0	0	0	*	0
O1-O3	0	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	1	1	1	+	+
E1-E5	1	2	1	+	+
E6-E9	+	0	+	0	0
W1-W4	0	0	0	0	0
O1-O3	0	0	0	0	0
O4-O6	0	0	0	0	0

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 13

POPULATION USING OPIATES (OTHER THAN HEROIN)
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1	1	2	2	+
E1-E5	2	2	2	2	1
E6-E9	+	+	+	+	0
O1-O3	+	1	0	1	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	2	2	1	*	+
E1-E5	2	3	2	*	1
E6-E9	1	2	0	*	0
O1-O3	0	0	0	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	1	2	2	2	1
E1-E5	2	3	3	2	1
E6-E9	0	0	0	0	0
O1-O3	+	1	0	-	0
O4-O6	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	1	1	+	*	+
E1-E5	1	1	1	*	+
E6-E9	0	0	0	*	0
O1-O3	0	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	1	2	2	2	+
E1-E5	2	2	2	2	1
E6-E9	+	1	+	+	0
W1-W4	0	0	0	-	*
O1-O3	+	1	0	1	0
O4-O6	0	0	0	0	0

\+ LESS THAN HALF OF ONE PERCENT.
\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

Drug Dependence

For the purpose of this analysis, a person is defined as having been physiologically drug dependent during the past 12 months if he or she falls in one or more of the following categories:

1. Used one of the following drugs nonmedically at least five times per week during the past 30 days: barbiturates/other downers, heroin, or other opiates.

2. Experienced sickness (i.e., withdrawal symptoms) because use of addictive drugs was stopped; symptoms include: "runny nose or eyes," "flushed or sweaty," "chills," "nausea or vomiting," "stomach cramps," "diarrhea," "muscle pains," etc.

3. Was detoxified because of drug use.

For the purpose of this analysis, a person is classified as psychologically drug dependent who experiences sickness (i.e., withdrawal symptoms) because he or she stopped use of one or more non-addictive drugs; the symptoms are the same as defined earlier for physiological addiction.

From the results obtained, it is estimated that 3 percent of DOD junior enlisted personnel were physiologically drug dependent and that a total of 4 percent were physiologically or psychologically drug dependent at some time during the preceding 12 months. The percentage of E1-E5's who were drug dependent is depicted in Table 14.

TABLE 14

DRUG DEPENDENCE

(PERCENTAGE OF E1-E5 POPULATION)

TYPE OF DEPENDENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
PHYSIOLOGICAL	3	4	3	4	1
PHYSIOLOGICAL AND/OR PSYCHOLOGICAL	4	5	4	5	1

Consequences of Drug Use

The respondents were asked to indicate whether each of two consequences of nonmedical drug use had occurred during the past 12 months. Table 15 shows that 19 percent of the junior enlisted respondents reported suffering at least one of the consequences during the preceding 12 months.

TABLE 15

SELECTED CONSEQUENCES OF DRUG USE
(PERCENTAGE OF E1-E5 POPULATION)

CONSEQUENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
USED MORE DRUGS THAN PLANNED	10	9	13	14	6
HIGH MORE THAN 1 DAY AT A TIME	17	16	22	24	9
TOTAL WITH EITHER OF THE 2 CONSEQUENCES	19	18	25	27	11

The respondents were also asked to indicate whether each of 15 physical, social or work consequences had occurred because of their use of drugs during the past 12 months. Ten percent of the junior enlisted personnel reported suffering at least one of the 15 consequences during that period (Table 16).

Junior enlisted personnel who reported one or more of the 17 consequences[1] experienced them a median of three times.[2]

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[1] This analysis combines both groups of consequences.

[2] A person experiencing consequences (say) three times could have experienced one consequence three times, three different consequences one time each, or another combination.

TABLE 16

SPECIFIC CONSEQUENCES OF DRUG USE DURING PAST 12 MONTHS

(PERCENTAGE OF E1-E5 POPULATION)

CONSEQUENCES	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ILLNESS KEPT FROM DUTY 1 WEEK OR LONGER	2	3	1	2	+
DIDN'T GET PROMOTED	3	4	3	5	1
GOT LOWER SCORE ON EFFICIENCY OR PERFORMANCE REPORT	3	3	3	5	1
RECEIVED JUDICIAL OR ARTICLE 15 PUNISHMENT	4	5	4	5	2
ARRESTED FOR DRIVING AFTER USING DRUGS	1	2	1	2	1
ARRESTED FOR NON-DRIVING DRUG INCIDENT	4	4	4	6	2
INCARCERATED DUE TO DRUG USE	2	1	2	3	1
HURT IN ACCIDENT CONNECTED WITH DRUG USE	2	2	2	2	+
DRUG USE CAUSED ACCIDENT WHERE OTHERS HURT OR PROPERTY DAMAGED	1	1	2	2	1
SPOUSE THREATENED TO LEAVE	2	2	2	2	1
HIT SPOUSE OR CHILDREN	1	1	1	1	+
SPOUSE LEFT	1	1	1	1	+
ENTERED REHABILITATION OR TREATMENT PROGRAM	2	2	1	2	2
ATTENDED TRAINING OR EDUCATION PROGRAM	2	3	1	3	1
DETOXIFIED	1	1	1	1	+
TOTAL WITH ANY CONSEQUENCES[a]	10	11	13	15	5

[a]PERCENTAGE OF POPULATION REPORTING AT LEAST ONE OF THE CONSEQUENCES DURING THE PAST 12 MONTHS.

+ LESS THAN ONE-HALF OF ONE PERCENT.

Work Impairment

Turning now to a more specific focus on work impairment because of drug use, four types of work impairment are considered: (1) "lowered performance," (2) "late for work or left early,: (3) "did not come to work," and (4) "high while working."

The type of work impairment most frequently reported by junior enlisted personnel was "high while working" (19 percent); nearly one-half of the E1-E5 respondents indicating this had occurred reported experiencing this on 40 or more days during the preceding 12 months. Substantially lower proportions of E1-E5 respondents reported other work impairments, as shown in Table 17, and nearly all of them also reported being "high while working."

TABLE 17

WORK IMPAIRMENT BECAUSE OF DRUG USE
(PERCENTAGE OF E1-E5 POPULATION)

TYPE OF IMPAIRMENT	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
LOWERED PERFORMANCE	10	12	15	13	3
LATE FOR WORK/LEFT EARLY	6	8	8	8	2
DID NOT COME TO WORK	4	6	4	5	1
HIGH WHILE WORKING	19	21	26	25	8
TOTAL WITH ANY IMPAIRMENT	21	22	28	28	9

Section 3: ALCOHOL USE--PREVALENCE AND CONSEQUENCES AMONG MILITARY PERSONNEL

Prevalence of Alcohol Use

The percentage of the population that drank any alcohol during the past 30 days is depicted in Table 18.

TABLE 18

POPULATION USING ALCOHOL DURING PAST 30 DAYS

(PERCENTAGE)

PAY GRADE GROUP	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
TOTAL WORLDWIDE	83	80	86	86	82
E1-E5	83	81	88	86	82
E6-E9	77	75	78	83	78
W1-W4	76	76	80	-	*
O1-O3	83	80	88	91	82
O4-O6	91	92	94	84	90

\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

The principal point derived from these data is that most military personnel (83 percent) drank at least occasionally. In general, the highest prevalence of drinking any alcohol was recorded by senior officers, followed by junior officers and junior enlisted personnel, senior enlisted personnel and, warrant officers.

For all respondents worldwide, beer was the most commonly consumed beverage; it was drunk by 73 percent of all military personnel at least once within the past 30 days, and by about one-fourth (26 percent) at least three times a week. Hard liquor (including mixed drinks) was consumed by about one-half of the respondents (51 percent) within the past 30 days, but only 8 percent drank hard liquor as often as three times a week. Wine was the least frequently consumed beverage: only 35 percent of the military personnel had drunk any wine during the past 30 days, and only 4 percent had done so as often as three times a week.

Regional differences in drinking patterns are generally slight with the exception that consumption of wine is more prevalent in Europe than in other regions.

Heavy Drinking

We define "heavy drinking" as consumption of eight or more drinks in a single day. Table 19 shows that beer was the beverage that was heavily consumed by the most respondents. On a typical day in which beer was consumed, 8 percent drank eight or more "drinks" (a "drink" is one 12 ounce can, bottle or glass). Heavy drinking of wine was rarely reported, (a "drink" is one four ounce glass), but heavy drinking of hard liquor was reportedly nearly as common as heavy drinking of beer; 6 percent of all respondents reported consuming eight or more drinks of hard liquor on a typical drinking day during the past 30 days.

TABLE 19

QUANTITY CONSUMED ON A TYPICAL DRINKING DAY DURING PAST 30 DAYS--WORLDWIDE TOTAL

(PERCENTAGE OF POPULATION)

BEVERAGE/ QUANTITY	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
BEER					
8-11 DRINKS	5	5	7	7	3
12 OR MORE DRINKS	3	3	5	4	1
WINE					
8-11 DRINKS	+	+	+	+	+
12 OR MORE DRINKS	1	1	1	1	1
HARD LIQUOR					
8-11 DRINKS	4	3	5	6	2
12 OR MORE DRINKS	2	2	3	2	1

+ LESS THAN HALF OF ONE PERCENT

Heavy drinking was reported almost exclusively by enlisted personnel. Twelve percent of E1-E5's and 4 percent of E6-E9's worldwide reported heavy drinking of beer; only 1 percent of each enlisted group reported heavy drinking of wine. The comparable figures for hard liquor were: E1-E5's, 8 percent;

E6-E9's, 3 percent. Only about 1 percent or less of each officer or warrant officer group worldwide reported heavy drinking of any beverage.

The preceding discussion was concerned with typical drinking during the past 30 days. Now we focus on the frequency that a person engaged in heavy drinking during the past 12 months. Table 20 shows that 21 percent of all respondents reported they had engaged in heavy drinking of beer at least one a week during the past 12 months; the comparable figures for wine and hard liquor were about 5 percent and 11 percent, respectively.

TABLE 20

HEAVY DRINKERS[1]--WORLDWIDE TOTAL
(PERCENTAGE OF POPULATION)

BEVERAGE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
BEER	21	22	25	28	13-14
WINE	5-6	8	5-6	7	3-4
HARD LIQUOR	11	12	14	13	7-8

[1]DEFINED AS A PERSON WHO DRANK EIGHT OR MORE 12 OUNCE CANS, GLASSES, OR BOTTLES OF BEER; EIGHT OR MORE FOUR OUNCE GLASSES OF WINE; OR EIGHT OR MORE DRINKS OF HARD LIQUOR IN A SINGLE DAY AT LEAST ONCE A MONTH DURING THE PAST 12 MONTHS.

The worldwide patterns of heavy drinking by pay grade group are as described previously for typical drinking, but the rates are higher. Heavy drinking was rarely reported by officers or warrant officers. Twenty-eight percent of E1-E5's and about 10 percent of E6-E9's reported heavy drinking of beer; the comparable figures for wine were 8 percent and about 1 percent of the E1-E5's and E6-E-9's, respectively. Fourteen percent of the E1-E5's and about 5 percent of E6-E9's reported heavy drinking of hard liquor.

Adverse Physiological Effects

There is compelling evidence that a person consuming a daily average of five ounces or more of ethanol during a year is at high risk of developing severe medical problems (e.g., cirrhotic or precirrhotic conditions).[1] Based on this threshold of presumptive harm, 7.9 percent of all DOD respondents are at high risk. Table 21 depicts the data by Service and pay grade group.

TABLE 21

POPULATION AT HIGH RISK FOR SEVERE MEDICAL PROBLEMS
(PERCENTAGE)

PAY GRADE GROUP	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
TOTAL	7.9	9.2	9.9	10.1	3.6
E1-E5	10.9	12.2	13.9	12.9	5.3
E6-E9	3.1	4.9	2.7	2.6	1.3
W1-W4	0.2	0	1.0	-	*
O1-O3	0.7	1.5	0.1	0.9	0.4
O4-O6	0.6	0	0	2.4	1.0

\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

Alcohol Dependence

For the purpose of this analysis, a person is defined as "alcohol dependent" who, during the preceding 12 month period, experienced one or more of the following symptoms during at least 48 of the 52 weeks: (1) tremors (shakes), (2) morning drinking, (3) impaired control, and (4) blackouts.

It is estimated that 7 percent of the military personnel worldwide were alcohol dependent during the preceding 12 months (Table 22). Alcohol dependency occurred predominantly among junior enlisted personnel (10 percent) and senior enlisted personnel (3 percent); it was rare among warrant officers and commissioned officers.

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[1] Five ounces of ethanol is equivalent to approximately ten 12 ounce cans of beer, ten four ounce glasses of wine, or seven drinks of hard liquor (at 1.7 ounces of hard liquor per drink).

TABLE 22

ALCOHOL DEPENDENCE DURING PAST 12 MONTHS

(PERCENTAGE OF POPULATION)

PAY GRADE GROUP	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
TOTAL	7	8	9	11	4
E1-E5	10	11	12	14	5
E6-E9	3	3	5	4	2
W1-W4	+	0	0	-	*
O1-O3	1	1	+	5	+
O4-O6	+	0	1	1	1

+ LESS THAN HALF OF ONE PERCENT.
* NOT APPLICABLE.
- LESS THAN 30 RESPONDENTS.

The patterns shown are quite consistent with the heavy drinking patterns discussed previously. This is to be expected because of the substantial correlation between heavy drinking and alcohol dependency.

Consequences of Alcohol Use

The respondents were asked to indicate whether each of two consequences of alcohol use had occurred during the past 12 months. Table 23 shows that 23 percent of all respondents reported suffering at least one of the consequences.

TABLE 23

SELECTED CONSEQUENCES OF ALCOHOL USE DURING PAST 12 MONTHS

(PERCENTAGE OF POPULATION)

CONSEQUENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
BECAME DRUNK WITHOUT PLANNING TO	20	16	25	23	1[illegible]
DRUNK MORE THAN ONE DAY AT A TIME	11	10	16	16	6
TOTAL WITH EITHER CONSEQUENCE	23	19	31	29	20

Junior enlisted personnel were the most likely to suffer at least one consequence, followed in turn by senior enlisted personnel, junior officers, senior officers, and warrant officers.

The respondents were also asked to indicate whether each of 15 physical, social, or work consequences had occurred because of their alcohol use during the past 12 months. Eleven percent reported suffering at least one of the 15 consequences during that period (Table 24).

Among those who reported that any of the 17 consequences[1] had occurred, they had occurred a median of three times.

Work Impairment

The percentage of the population reporting work impairment because of their alcohol use during the preceding 12 months is shown in Table 25. "Lowered performance" was the type of work impairment most frequently reported; it was reported by 22 percent of the total respondents and by 26 percent of E1-E5's and this occurred a median of two to three times. The figures on "total with any impairment" generally follow the patterns of heavy drinking discussed earlier. The patterns of impairment by pay grade group are in the following rank order by percentage suffering impairment: E1-E5's, E6-E9's, O1-O3's, O4-O6's, and W1-W4's.

[1] This analysis combines the two groups of consequences.

TABLE 24

CONSEQUENCES OF ALCOHOL USE DURING PAST 12 MONTHS--TOTAL DOD
(PERCENTAGE OF POPULATION)

CONSEQUENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ILLNESS KEPT FROM DUTY 1 WEEK OR LONGER	2	2	2	2	1
DID NOT GET PROMOTED	2	2	1	3	1
GOT LOWER SCORE ON EFFICIENCY OR PERFORMANCE REPORT	2	2	3	4	1
RECEIVED JUDICIAL OR ARTICLE 15 PUNISHMENT	2	3	2	3	1
ARRESTED FOR DRIVING AFTER DRINKING	3	3	3	5	2
ARRESTED FOR NON DRIVING DRINKING INCIDENT	2	3	3	4	1
INCARCERATED DUE TO DRINKING	3	2	4	5	1
HURT IN ACCIDENT CONNECTED WITH DRINKING	2	2	4	4	1
DRINKING CAUSED ACCIDENT WHERE OTHERS HURT OR PROPERTY DAMAGED	2	2	3	3	1
SPOUSE THREATENED TO LEAVE	2	2	2	2	1
HIT SPOUSE OR CHILDREN	1	1	1	2	1
SPOUSE LEFT	1	1	*	1	*
ENTERED REHABILITATION OR TREATMENT PROGRAM	2	2	2	2	1
ATTENDED TRAINING OR EDUCATION PROGRAM	2	2	2	3	1
DETOXIFIED	1	1	1	1	*
TOTAL WITH ANY CONSEQUENCE 1/	11	11	14	17	6

1/ PERCENTAGE OF POPULATION WITH AT LEAST ONE OF THE CONSEQUENCES DURING THE PAST 12 MONTHS.
* LESS THAN HALF OF ONE PERCENT.

TABLE 25

WORK IMPAIRMENT BECAUSE OF ALCOHOL USE DURING PAST 12 MONTHS

(PERCENTAGE OF POPULATION)

IMPAIRMENT/ PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
LOWERED PERFORMANCE					
TOTAL	22	19	30	29	17
E1-E5	26	23	34	32	19
E6-E9	17	13	22	22	14
W1-W4	9	4	12	-	*
O1-O3	15	12	28	20	10
O4-O6	10	7	8	14	14
LATE FOR WORK OR LEFT EARLY					
TOTAL	13	13	17	16	10
E1-E5	16	15	21	17	12
E6-E9	9	9	10	15	7
W1-W4	2	2	0	-	*
O1-O3	7	8	9	5	5
O4-O6	4	1	7	8	5
DID NOT COME TO WORK					
TOTAL	5	6	5	5	2
E1-E5	6	8	7	6	2
E6-E9	2	2	3	3	2
W1-W4	1	1	0	-	*
O1-O3	0	0	0	2	0
O4-O6	1	0	0	0	2
DRUNK/HIGH WHILE WORKING					
TOTAL	11	11	16	15	6
E1-E5	15	16	21	19	7
E6-E9	5	4	7	7	3
W1-W4	1	1	0	-	*
O1-O3	3	2	6	1	2
O4-O6	3	0	7	0	3
TOTAL WITH ANY IMPAIRMENT					
TOTAL	27	24	35	34	20
E1-E5	31	29	40	38	24
E6-E9	19	16	25	25	16
W1-W4	9	4	12	-	*
O1-O3	17	15	29	21	12
O4-O6	12	7	14	15	15

\- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.
\+ LESS THAN HALF OF ONE PERCENT.

Section 4: COMPARISON OF DRUG AND ALCOHOL PREVALENCE AMONG MILITARY AND CIVILIAN POPULATIONS

This analysis is restricted to the subpopulation at highest risk for nonmedical drug use in both military and civilian populations: persons 18 through 25 years of age. The data have been standardized with respect to the variables that are most closely correlated with nonmedical drug use: sex, age, marital status, and education. Standardization with respect to these variables serves to provide prevalence rates that are not biased by the differences in occurrence of these characteristics in the two populations. The specific procedures employed to standardize the data and the limitations in the analysis are described in the main report.

Table 26 shows the prevalence of nonmedical drug use among military personnel and comparable civilians, ages 18 through 25. Prevalence of current nonmedical drug use for military personnel is slightly lower or equal to civilian use for all drug types analyzed, with the exception of amphetamines or other uppers. Prevalence of annual use is lower for military personnel than civilians with respect to four drug types and higher than civilians for three drug types. There is, thus, no general pattern of nonmedical drug use being more prevalent for military personnel than civilians.

Regarding alcohol use, slightly higher proportions of military personnel than civilians drank at all during the past 30 days and the past year.

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TABLE 26

PREVALENCE OF NONMEDICAL DRUG USE
AND ALCOHOL USE AMONG MILITARY PERSONNEL
AND COMPARABLE CIVILIANS--AGES 18-25
(PERCENTAGE OF 18-25 YEAR OLD POPULATION)

TYPE	MILITARY (n= 8224)	COMPARABLE CIVILIANS[1] (n= 2022)
MARIJUANA/HASHISH		
PAST 30 DAYS	40	42
PAST 12 MONTHS	52	54
AMPHETAMINES OR OTHER UPPERS		
PAST 30 DAYS	10	4
PAST 12 MONTHS	21	12
COCAINE		
PAST 30 DAYS	7	10
PAST 12 MONTHS	18	23
HALLUCINOGENS		
PAST 30 DAYS	5	5
PAST 12 MONTHS	13	12
BARBITURATES OR OTHER DOWNERS		
PAST 30 DAYS	4	4
PAST 12 MONTHS	9	10
TRANQUILIZERS		
PAST 30 DAYS	3	3
PAST 12 MONTHS	9	12
HEROIN		
PAST 30 DAYS	1	1
PAST 12 MONTHS	3	1
ALCOHOL		
PAST 30 DAYS	84	82
PAST 12 MONTHS	93	90

[1] DATA STANDARDIZED WITH RESPECT TO SEX, AGE, MARITAL STATUS, AND EDUCATION. BASED ON SPECIAL TABULATIONS FROM THE 1979 NATIONAL SURVEY ON DRUG ABUSE.

TECHNICAL NOTE

This technical note contains a description of the sample design, the confidence limits, and the number of respondents.

Sample Design

The DOD stipulated that a sample be drawn of all active duty military personnel throughout the world from which reliable estimates of drug and alcohol use could be made with known degrees of error for each of the Military Services, for five pay grade groupings, and for three main geographical regions and "Other Locations." It was further stipulated that the response rate among sampled personnel be 80 percent or higher, without replacements.

Because of budgetary and time constraints, it was not possible to survey every servicemember in each of the more than 300 locations throughout the world. These considerations dictated a design that sampled both personnel and locations by probability means. A stratified multistage probability sample was subsequently developed and implemented. Both sites and personnel were randomly selected. Differential personnel sampling rates were used to obtain sufficient sample sizes in the various respondent subgroups. Sample weighting procedures were applied to put the complete respondent sample into balance; these are described in the main report.

The final sample size required for each Service by geographical region is shown in Table 27. The sample was composed of 19,582 military personnel stationed at 81 installations.[1] As shown in Table 28, the survey respondents were predominately male, white and between the ages of 18 through 25. As indicated also, the sample was very representative of all DOD personnel, worldwide, with respect to the characteristics shown. The population represented by the sample is depicted in Tables 29 and 30.

At each survey site, a random sample was drawn from the most current listing of all personnel assigned to the installation.[2] The random selection was made from all personnel

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[1] An installation was composed of all permanent parent and tenant units at a base, post, camp, station or ships in a designated location.

[2] The detailed sample selection procedures were designed to accommodate unique Service personnel accounting systems and local capabilities to produce the random sample.

TABLE 27

SAMPLE ALLOCATION

REGION	NO. SITES	SAMPLE
ARMY	(19)	(6,239)
CONUS	8	3,026
EUROPE	4	1,320
PACIFIC	5	1,548
OTHER	2	345
NAVY	(30)	(5,202)
CONUS	17	3,202
EUROPE	5	600
PACIFIC	7	1,174
OTHER	1	226
MARINE CORPS	(10)	(2,861)
CONUS	7	1,917
PACIFIC	3	944
AIR FORCE	(22)	(5,280)
CONUS	11	2,464
EUROPE	5	1,066
PACIFIC	5	1,284
OTHER	1	466
TOTAL	(81)	(19,582)
CONUS	43	10,609
EUROPE	14	2,986
PACIFIC	20	4,950
OTHER	4	1,037

TABLE 28

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS AND ALL DOD MILITARY PERSONNEL

(PERCENTAGE OF POPULATION)

CHARACTERISTIC	TOTAL SURVEY	DOD ACTUAL[1]
SEX		
MALE	91	92
FEMALE	9	8
RACE/ETHNIC		
WHITE/CAUCASIAN	71	73
AFRO AMERICAN/BLACK	18	19
HISPANIC	5	4
ORIENTAL/ASIAN/PACIFIC ISLANDER	3	1
AMERICAN INDIAN/ALASKAN NATIVE	1	2
OTHER	2	1
MARITAL STATUS		
MARRIED	53	52
NOT MARRIED	47	48
AGE		
17 OR UNDER	1	1
18-25	55	56
26-29	15	14
30-34	13	13
35-39	10	10
40 OR OVER	6	6

[1]MARCH 1980: DEFENSE MANPOWER DATA CENTER.

TABLE 29

POPULATION REPRESENTED BY THE SAMPLE

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1,393,269	454,158	416,283	128,951	393,878
E1-E5	924,659	304,537	282,565	95,412	242,146
E6-E9	251,356	77,221	85,085	18,951	70,099
W1-W4	14,498	9,066	3,091	2,341	*
O1-O3	126,085	39,207	28,121	8,243	50,514
O4-O6	76,671	24,127	17,421	4,004	31,119
EUROPE					
TOTAL	287,004	190,205	21,625	*	75,174
E1-E5	194,521	131,295	13,485	*	49,741
E6-E9	63,700	42,299	4,467	*	16,934
W1-W4	2,979	2,713	267	*	*
O1-O3	16,879	9,407	1,976	*	5,497
O4-O6	8,924	4,491	1,431	*	3,002
PACIFIC					
TOTAL	165,471	36,263	45,596	39,388	44,224
E1-E5	103,543	19,225	24,553	29,281	30,484
E6-E9	40,275	11,252	13,211	6,531	9,281
W1-W4	2,000	802	851	347	*
O1-O3	11,668	2,692	3,464	2,425	3,086
O4-O6	7,984	2,291	3,517	803	1,374
OTHER LOCATIONS					
TOTAL	44,023	18,388	14,892	*	10,744
E1-E5	29,170	13,159	8,667	*	7,344
E6-E9	9,595	3,093	4,250	*	2,251
W1-W4	625	352	273	*	*
O1-O3	2,881	1,160	911	*	810
O4-O6	1,753	624	790	*	339
TOTAL WORLDWIDE					
TOTAL	1,889,766	699,013	498,395	168,338	524,020
E1-E5	1,251,893	468,216	329,269	124,693	329,715
E6-E9	364,926	133,866	107,013	25,482	98,564
W1-W4	20,103	12,933	4,482	2,688	*
O1-O3	157,512	52,465	34,472	10,668	59,907
O4-O6	95,332	31,533	23,159	4,808	35,833

* NOT APPLICABLE.

TABLE 30

POPULATION OF E1-E5's REPRESENTED BY SAMPLE

GEOGRAPHICAL REGION	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	924,659	304,537	282,565	95,412	242,146
EAST	608,118	234,696	217,530	39,228	116,664
WEST	316,542	69,841	65,035	56,184	125,422
EUROPE					
TOTAL	194,521	131,295	13,485	*	49,741
GERMANY	155,380	131,295	*	*	24,085
ITALY	7,477	*	7,477	*	*
ENGLAND	14,282	*	653	*	13,629
SPAIN	17,382	*	5,355	*	12,028
PACIFIC					
TOTAL	103,543	19,225	24,553	29,281	30,484
HAWAII	29,426	5,628	10,135	10,477	3,186
JAPAN	40,576	3,590	5,994	18,805	12,187
KOREA	18,943	10,007	*	*	8,936
PHILIPPINES	10,170	*	3,995	*	6,175
GUAM	4,429	*	4,429	*	*
OTHER LOCATIONS					
TOTAL	29,170	13,159	8,667	*	7,344
PANAMA CANAL	5,976	5,976	*	*	*
ALASKA	14,527	7,183	*	*	7,344
GUANTANAMO BAY	8,667	*	8,667	*	*
TOTAL WORLDWIDE	1,251,893	468,216	329,269	124,693	329,715

* NOT APPLICABLE.

in pay grades E1 through O6 of the one designated Service permanently assigned to organizations included in the specified installation. The last two digits of the individual's Social Security Account Number were used as the device for random selection of the respondents. Not included in the population base from which a sample was drawn were those personnel in recruit or basic training and those personnel in units known or expected to be at sea or deployed away from the installation at the time of the questionnaire administration. Personnel selected for the sample could be excused from questionnaire administration only for the following authorized reasons:

- on leave from the parent organization
- on temporary duty away from the installation
- absent without leave
- assigned a permanent change of station
- separated from the Service

Absences for any other reason were designated as "no-shows."

It is well known that a survey based on samples of a population can only approximate the level of accuracy that would be obtained if it were possible for the entire population to participate in the survey. Because of this, there is a need to know the precision of the estimates from a particular sample survey. The 95 percent confidence limits for any percentage estimate reported in this volume are provided later in this Technical Note. These confidence limits are particularly important where estimates are given for subgroups of the population. The reader should be aware that those subgroups with relatively few cases will have relatively greater margins of error than those subgroups with a larger number of respondents. This notably includes subgroups of officers and warrant officers. Regional data on officers should be viewed with particular caution, because of the small number of respondents in those subgroups. The number of respondents in each subgroup is depicted in Tables 31 and 32.

Confidence Limits and Significance of Differences

An important issue in all prevalence surveys based on data obtained from samples of a population is the extent to which one can be confident that the prevalence estimates obtained accurately reflect the true prevalence for the entire population. That is, if every servicemember responded to the questionnaire, would the prevalence rate be substantially different from that obtained from the sample of personnel surveyed?

For any particular percentage given in the prevalence

TABLE 31

NUMBER OF RESPONDENTS

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	8,286	2,345	2,802	1,194	1,945
E1-E5	5,475	1,545	1,927	873	1,130
E6-E9	1,717	527	635	188	367
W1-W4	74	35	23	16	*
O1-O3	624	165	152	67	240
O4-O6	396	73	65	50	208
EUROPE					
TOTAL	2,329	923	557	*	849
E1-E5	1,547	660	361	*	526
E6-E9	476	175	128	*	173
W1-W4	18	14	4	*	*
O1-O3	163	46	32	*	85
O4-O6	125	28	32	*	65
PACIFIC					
TOTAL	3,766	1,076	1,084	624	982
E1-E5	2,531	659	738	478	656
E6-E9	836	283	245	94	214
W1-W4	37	19	13	5	*
O1-O3	223	69	59	29	66
O4-O6	139	46	29	18	46
OTHER LOCATIONS					
TOTAL	887	279	228	*	380
E1-E5	601	195	135	*	271
E6-E9	202	65	69	*	68
W1-W4	6	3	3	*	*
O1-O3	47	10	10	*	27
O4-O6	31	6	11	*	14
TOTAL WORLDWIDE					
TOTAL	15,268	4,623	4,671	1,818	4,156
E1-E5	10,154	3,059	3,161	1,351	2,583
E6-E9	3,231	1,050	1,077	282	822
W1-W4	135	71	43	21	*
O1-O3	1,057	290	253	96	418
O4-O6	691	153	137	68	333

* NOT APPLICABLE

TABLE 32

NUMBER OF E1-E5 RESPONDENTS

GEOGRAPHICAL REGION	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	5,475	1,545	1,927	873	1,130
EAST	3,612	1,236	1,379	492	505
WEST	1,863	309	548	381	625
EUROPE					
TOTAL	1,547	660	361	*	526
GERMANY	859	660	*	*	199
ITALY	181	*	181	*	*
ENGLAND	198	*	27	*	171
SPAIN	309	*	153	*	156
PACIFIC					
TOTAL	2,531	659	738	478	656
HAWAII	652	201	246	115	90
JAPAN	1,011	106	292	363	250
KOREA	545	352	*	*	193
PHILIPPINES	214	*	91	*	123
GUAM	109	*	109	*	*
OTHER LOCATIONS					
TOTAL	601	195	135	*	271
PANAMA CANAL	85	85	*	*	*
ALASKA	381	110	*	*	271
GUANTANAMO BAY	135	*	135	*	*
TOTAL WORLDWIDE	10,154	3,059	3,161	1,351	2,583

* NOT APPLICABLE.

data tables, we cannot know exactly how much error has resulted from sampling. However, reasonably good estimates can be made of the range within which the responses of the total population would fall. The estimation of confidence limits for the results of the survey is a complex statistical decision and procedure. The following formula has been used to determine asymmetric confidence limits at the 95% level of confidence for sample percentage estimates:

$$P_L = p' - 1.96 \left[P_L(1-p_L)/n\right]^{\frac{1}{2}} \quad (1.3)$$

$$P_U = p' + 1.96 \left[P_U(1-p_U)/n\right]^{\frac{1}{2}} \quad (1.3)$$

Where:

P_L = lower limit of the confidence interval

p' = the estimate based on the sample

n = the sample size

P_U = the upper limit of the confidence interval

Table 33 depicts the upper and lower confidence limits for sample estimates.

In comparing two sample estimates, it is important to determine whether the difference between the two estimates is statistically significant. That is, can the difference reasonably be attributable to sampling variations or is it "real." Table 34 displays, for various sample sizes, the minimum difference between two percentage estimates that would be required for the difference to be statistically significant at the .05 level of confidence. For example, if a percentage result is 20 percent for E1-E5's and 15 percent for E6-E9's and the respective sample sizes were 1,000 and 500, there would have to be a difference of at least 5.6 percent for it to be considered a real difference and not attributable to chance. Thus, for this example, the difference would not be statistically significant at the .05 level.

TABLE 33

CONFIDENCE LIMITS FOR SAMPLE ESTIMATES

	OBSERVED PERCENTAGE														
	1.0%		3.0%		5.0%		10.0%		20.0%		30.0%		40.0%		50.0%
	-	+	-	+	-	+	-	+	-	+	-	+	-	+	±
n= 100	0.9%	6.7%	2.3%	7.8%	3.3%	8.6%	5.4%	10.2%	8.3%	11.9%	10.2%	12.6%	11.5%	12.7%	12.4%
200	0.8%	3.8%	1.9%	4.8%	2.7%	5.5%	4.3%	6.7%	6.2%	8.1%	7.6%	8.7%	8.4%	9.0%	8.8%
300	0.7%	2.8%	1.7%	3.6%	2.4%	4.3%	3.6%	5.3%	5.2%	6.4%	6.2%	7.1%	7.0%	7.4%	7.3%
400	0.7%	2.2%	1.6%	3.0%	2.2%	3.5%	3.2%	4.5%	4.5%	5.5%	5.5%	6.1%	6.0%	6.3%	6.3%
500	0.6%	1.9%	1.5%	2.6%	2.0%	3.1%	3.0%	4.0%	4.2%	4.9%	5.0%	5.4%	5.4%	5.7%	5.6%
600	0.6%	1.7%	1.4%	2.3%	1.9%	3.0%	2.7%	3.5%	3.8%	4.5%	4.6%	5.0%	5.0%	5.2%	5.2%
700	0.6%	1.5%	1.2%	2.1%	1.8%	2.5%	2.5%	3.2%	3.5%	4.2%	4.3%	4.6%	4.5%	4.8%	4.8%
800	0.6%	1.4%	1.2%	2.0%	1.7%	2.3%	2.4%	3.0%	3.3%	3.8%	4.0%	4.3%	4.1%	4.5%	4.5%
900	0.5%	1.3%	1.1%	1.8%	1.6%	2.2%	2.3%	2.8%	3.2%	3.6%	3.7%	4.1%	4.1%	4.3%	4.3%
1000	0.5%	1.1%	1.1%	1.7%	1.5%	2.1%	2.2%	2.7%	3.0%	3.4%	3.5%	3.8%	3.8%	4.0%	4.1%
2000	0.4%	0.7%	0.8%	1.1%	1.1%	1.4%	1.6%	1.9%	2.2%	2.4%	2.6%	2.7%	2.8%	2.8%	2.8%
3000	0.4%	0.6%	0.7%	0.9%	0.9%	1.1%	1.4%	1.5%	1.8%	1.9%	2.1%	2.2%	2.3%	2.3%	2.3%
4000	0.3%	0.5%	0.6%	0.7%	0.8%	0.9%	1.1%	1.3%	1.6%	1.7%	1.8%	1.9%	2.0%	2.0%	2.0%
5000	0.3%	0.4%	0.5%	0.6%	0.7%	0.8%	1.0%	1.1%	1.4%	1.5%	1.7%	1.7%	1.8%	1.8%	1.8%
10000	0.2%	0.3%	0.4%	0.5%	0.5%	0.6%	0.7%	0.8%	1.0%	1.0%	1.2%	1.2%	1.2%	1.2%	1.3%
15000	0.2%	0.2%	0.3%	0.4%	0.4%	0.5%	0.6%	0.6%	0.8%	0.8%	0.9%	1.0%	1.0%	1.0%	1.0%
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	±
	99.0%		97.0%		95.0%		90.0%		80.0%		70.0%		60.0%		50.0%
	OBSERVED PERCENTAGE														

TABLE 34

DIFFERENCES REQUIRED FOR SIGNIFICANCE ACCORDING TO SAMPLE SIZE

SIZE OF SAMPLES COMPARED	OBSERVED PERCENTAGE 10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
3300 and 3300	1.9%	2.5%	2.7%	2.9%	3.0%	3.1%	3.1%
3000	1.9%	2.6%	2.8%	2.9%	3.0%	3.1%	3.2%
2500	2.0%	2.7%	2.9%	3.0%	3.2%	3.3%	3.3%
2000	2.2%	2.9%	3.1%	3.3%	3.4%	3.5%	3.6%
1500	2.4%	3.2%	3.4%	3.6%	3.7%	3.8%	4.0%
1000	2.8%	3.6%	4.0%	4.3%	4.4%	4.5%	4.6%
500	3.6%	4.9%	5.3%	5.6%	5.8%	6.0%	6.1%
3000 and 3000	2.0%	2.6%	2.8%	3.0%	3.1%	3.2%	3.3%
2500	2.1%	2.8%	3.0%	3.1%	3.3%	3.4%	3.4%
2000	2.2%	2.9%	3.2%	3.3%	3.5%	3.6%	3.6%
1500	2.4%	3.2%	3.5%	3.7%	3.8%	4.0%	4.1%
1000	2.8%	3.7%	4.1%	4.3%	4.5%	4.6%	4.7%
500	3.7%	4.9%	5.3%	5.6%	5.8%	6.0%	6.1%
2500 and 2500	2.2%	2.9%	3.1%	3.3%	3.4%	3.5%	3.6%
2000	2.3%	3.0%	3.3%	3.5%	3.6%	3.7%	3.8%
1500	2.5%	3.3%	3.6%	3.8%	4.0%	4.1%	4.2%
1000	2.9%	3.8%	4.2%	4.4%	4.6%	4.7%	4.8%
500	3.7%	5.0%	5.4%	5.7%	5.9%	6.1%	6.2%
2000 and 2000	2.4%	3.2%	3.5%	3.7%	3.8%	4.0%	4.1%
1800	2.5%	3.3%	3.5%	3.7%	4.0%	4.1%	4.2%
1600	2.6%	3.4%	3.7%	4.0%	4.1%	4.2%	4.3%
1400	2.7%	3.5%	3.8%	4.1%	4.3%	4.4%	4.5%
1200	2.8%	3.7%	4.1%	4.3%	4.5%	4.6%	4.7%
1000	2.9%	4.0%	4.3%	4.5%	4.7%	4.8%	4.9%
800	3.2%	4.3%	4.6%	4.9%	5.1%	5.2%	5.3%
600	3.5%	4.8%	5.1%	5.4%	5.6%	5.8%	5.9%
400	4.2%	5.6%	6.0%	6.3%	6.7%	6.9%	7.0%
200	5.7%	7.6%	8.2%	8.6%	9.0%	9.3%	9.5%

(CONTINUED)

SIZE OF SAMPLES COMPARED	OBSERVED PERCENTAGE 10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
1000 and 1000	3.4%	4.6%	4.9%	5.2%	5.4%	5.6%	5.7%
900	3.5%	4.7%	5.1%	5.4%	5.6%	5.7%	5.8%
800	3.6%	4.8%	5.2%	5.5%	5.7%	5.9%	6.0%
700	3.7%	5.0%	5.4%	5.7%	6.0%	6.1%	6.2%
600	4.0%	5.3%	5.7%	6.0%	6.2%	6.4%	6.6%
500	4.2%	5.6%	6.0%	6.3%	6.7%	6.9%	7.0%
400	4.5%	6.0%	6.6%	6.9%	7.2%	7.4%	7.5%
300	5.0%	6.8%	7.3%	7.7%	8.0%	8.2%	8.4%
200	5.9%	7.9%	8.5%	9.0%	9.5%	9.7%	9.9%
100	8.0%	10.7%	11.5%	12.3%	12.8%	13.1%	13.3%
900 and 900	3.6%	4.8%	5.2%	5.5%	5.7%	5.9%	6.0%
800	3.7%	5.0%	5.4%	5.7%	5.9%	6.0%	6.2%
700	3.8%	5.1%	5.5%	5.9%	6.1%	6.2%	6.4%
600	4.1%	5.4%	5.8%	6.1%	6.4%	6.6%	6.8%
500	4.3%	5.7%	6.1%	6.6%	6.8%	7.0%	7.1%
400	4.6%	6.1%	6.7%	7.0%	7.3%	7.5%	7.7%
300	5.1%	6.8%	7.4%	7.8%	8.1%	8.3%	8.5%
200	5.9%	8.0%	8.6%	9.2%	9.5%	9.8%	10.0%
100	8.0%	10.7%	11.6%	12.3%	12.7%	13.2%	13.4%
800 and 800	3.8%	5.1%	5.5%	5.8%	6.0%	6.2%	6.3%
700	4.0%	5.3%	5.7%	6.0%	6.2%	6.4%	6.6%
600	4.2%	5.5%	5.9%	6.3%	6.6%	6.8%	6.9%
500	4.3%	5.8%	6.2%	6.7%	7.0%	7.1%	7.3%
400	4.7%	6.2%	6.8%	7.2%	7.5%	7.6%	7.8%
300	5.2%	6.9%	7.5%	7.9%	8.2%	8.4%	8.6%
200	6.0%	8.0%	8.7%	9.3%	9.6%	9.9%	10.1%
100	8.1%	10.8%	11.8%	12.4%	12.9%	13.2%	13.5%

(CONTINUED)

TABLE 34 (CONTINUED)

DIFFERENCES REQUIRED FOR SIGNIFICANCE ACCORDING TO SAMPLE SIZE

SIZE OF SAMPLES COMPARED	OBSERVED PERCENTAGE 10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
1800 and 1800	2.5%	3.4%	3.6%	3.8%	4.1%	4.2%	4.3%
1600	2.6%	3.5%	3.7%	4.1%	4.2%	4.3%	4.4%
1400	2.7%	3.6%	4.0%	4.2%	4.4%	4.5%	4.6%
1200	2.8%	3.8%	4.2%	4.4%	4.6%	4.7%	4.8%
1000	3.0%	4.1%	4.4%	4.6%	4.8%	4.9%	5.0%
800	3.2%	4.4%	4.7%	5.0%	5.2%	5.3%	5.4%
600	3.6%	4.8%	5.2%	5.5%	5.7%	5.9%	6.0%
400	4.3%	5.6%	6.1%	6.4%	6.8%	6.9%	7.1%
200	5.7%	7.6%	8.2%	8.7%	9.0%	9.3%	9.5%
1600 and 1600	2.7%	3.6%	4.0%	4.2%	4.3%	4.4%	4.5%
1400	2.8%	3.7%	4.1%	4.3%	4.5%	4.6%	4.7%
1200	2.9%	3.8%	4.3%	4.5%	4.7%	4.8%	4.9%
1000	3.1%	4.2%	4.5%	4.7%	4.9%	5.0%	5.1%
800	3.3%	4.4%	4.8%	5.1%	5.3%	5.4%	5.5%
600	3.6%	4.9%	5.3%	5.6%	5.8%	5.9%	6.1%
400	4.3%	5.5%	6.1%	6.6%	6.8%	7.0%	7.1%
200	5.7%	7.6%	8.3%	8.7%	9.2%	9.4%	9.6%
1400 and 1400	2.9%	3.8%	4.2%	4.4%	4.6%	4.7%	4.8%
1200	3.0%	4.1%	4.4%	4.6%	4.8%	4.9%	5.0%
1000	3.1%	4.3%	4.6%	4.8%	5.0%	5.2%	5.3%
800	3.4%	4.5%	4.9%	5.2%	5.4%	5.5%	5.6%
600	3.7%	5.0%	5.4%	5.7%	5.9%	6.1%	6.2%
400	4.4%	5.8%	6.2%	6.7%	6.9%	7.1%	7.2%
200	5.8%	7.7%	8.3%	8.8%	9.2%	9.5%	9.7%
1200 and 1200	3.1%	4.2%	4.5%	4.8%	5.0%	5.1%	5.2%
1000	3.2%	4.4%	4.7%	5.0%	5.2%	5.3%	5.4%
800	3.5%	4.7%	5.0%	5.3%	5.5%	5.7%	5.8%
600	3.8%	5.1%	5.5%	5.8%	6.0%	6.2%	6.3%
400	4.4%	5.9%	6.3%	6.8%	7.0%	7.2%	7.4%
200	5.8%	7.8%	8.4%	8.9%	9.3%	9.6%	9.8%

SIZE OF SAMPLES COMPARED	OBSERVED PERCENTAGE 10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
700 and 700	4.1%	5.4%	5.9%	6.2%	6.4%	6.7%	6.8%
600	4.3%	5.7%	6.1%	6.4%	6.8%	7.0%	7.1%
500	4.5%	5.9%	6.4%	6.9%	7.1%	7.3%	7.5%
400	4.8%	6.3%	6.9%	7.3%	7.6%	7.8%	8.0%
300	5.3%	7.1%	7.6%	8.0%	8.4%	8.6%	8.8%
200	6.1%	8.2%	8.8%	9.4%	9.8%	10.0%	10.2%
100	8.2%	10.9%	11.8%	12.5%	13.0%	13.3%	13.6%
600 and 600	4.4%	5.9%	6.3%	6.8%	7.0%	7.2%	7.4%
500	4.7%	6.1%	6.7%	7.1%	7.4%	7.6%	7.7%
400	4.9%	6.6%	7.1%	7.5%	7.8%	8.0%	8.2%
300	5.4%	7.2%	7.8%	8.2%	8.6%	8.8%	9.0%
200	6.2%	8.3%	9.0%	9.6%	9.9%	10.2%	10.4%
100	8.2%	11.0%	12.0%	12.6%	13.1%	13.5%	13.7%
500 and 500	4.8%	6.4%	7.0%	7.4%	7.7%	7.9%	8.0%
400	5.1%	6.9%	7.4%	7.8%	8.1%	8.4%	8.5%
300	5.6%	7.5%	8.0%	8.5%	8.8%	9.2%	9.3%
200	6.3%	8.5%	9.3%	9.8%	10.2%	10.4%	10/6%
100	8.4%	11.1%	12.1%	12.8%	13.3%	13.6%	13.9%
400 and 400	5.4%	7.2%	7.8%	8.2%	8.6%	8.8%	9.0%
300	5.8%	7.8%	8.4%	8.9%	9.3%	9.6%	9.8%
200	6.7%	8.8%	9 6%	10.1%	10.5%	10.8%	11.0%
100	8.5%	11.4%	12.4%	13.1%	13.6%	13.9%	14.2%
300 and 300	6.2%	8.3%	9.0%	9.6%	9.9%	10.2%	10.4%
200	7.0%	9.3%	10.1%	10.6%	11.1%	11.4%	11.6%
100	8.8%	11.8%	12.7%	13.5%	14.0%	14.5%	14.8%
200 and 200	7.6%	10.2%	11.0%	11.6%	12.1%	12.5%	12.7%
100	9.4%	12.5%	13.5%	14.4%	14.9%	15.3%	15.6%
100 and 100	10.8%	14.5%	15.6%	16.5%	17.2%	17.7%	18.0%

Senator JEPSEN. General Mitchell, what is the purpose of the Army's study on cohesion involving tank crews? When will the study be completed? Are there any preliminary results?

General MITCHELL. The question provides an opportunity to clarify our objectives in conducting the study before any misunderstandings arise. The study referred to was an exploratory medical research effort conducted last year. The final results are to be prepared during June 1982. In my previous testimony I have covered the preliminary results.

The study involved interviewing about 80 tank crews that volunteered to discuss. First, their own use on non-use of drugs. Second, their perceptions and opinions of their fellow crew members. Third the depth and extent of the professional and social relationships within their crews.

The study had two principal limited objectives. We, in the Army, are working to foster greater cohesion in our military units. We know we need cohesion—it helps to steel our unit against the initial shock of battle. Cohesion is tough to quantify, consensus as to how best to measure it has been elusive. One objective of the tank crew study was to try for an increment in our cohesion measurement technology—to look for more indicators that might provide useful in other studies down the line. This was especially important to our medical researchers who deal with combat stress and prevention of battlefield stress casualties. Secondly, for seven years now our medical people have been telling us that drug use had the capacity to divide our units—that it detracted from the cohesion we had to have. The study was designed to back up their observations in a more quantified way.

From their medical perspective—concern about stress casualties in battle—cohesion in our units is as important an indicator of readiness in any of the other variables with which we are more familiar. We agree with them to the extent that cohesion is a dimenison of readiness—one that is receiving considerable attention today.

The data from the study are not yet fully analyzed. Being, in part, a developmental effort. Several different state of the art statistical technologies are being applied to the data. The study appears to be meeting its objectives. Measurement of cohesion will continue to be a challenge but clearly the study will contribute to future efforts. Drug use does alter patterns of relationships within our tank crews. In fact, our scientists believe at this preliminary juncture that our efforts at improved cohesion may have a significant impact in reducing drug use and will with certainty diminish the diversive potential of any drug use that remains.

In summary, the tank crew study was a study of cohesion and drug use.

CONTRABAND THROUGH THE U.S. MAILS

Senator JEPSEN. Dr. Beary, I am concerned over the trafficking of illicit drugs. Gentlemen, are illicit drugs being introduced onto military posts through the mail? If so, what action has DOD and the Services taken to prevent this from occurring?

Dr. BEARY. Senator Jepsen, we believe that illicit drugs have been introduced by mail to ships and overseas posts in the past. There have been a number of opinions from the U.S. Postal Service (USPS) in the past which have limited DOD's authority to deal with this problem. The Postal Service maintained that military commanders could not detain or open mail without approval of a Federal judge or a postal inspector. There were none of these aboard ships or at overseas locations. We have recently reached a tentative agreement, however, that DOD will be responsible for mail privacy issues overseas. Both DOD and USPS have developed proposed rules and published them in the Federal Register for a sixty day comment period. Comments will be reviewed in June 1982, and new rules will be published. We expect these rules to permit us to solve the drug smuggling through the mails problem, as designated military judges and commanders overseas would have the authority to order searches and inspections under procedures similar to those available under the authority of Federal judges and customs officials in the United States.

NAVY

Admiral MULLOY. Yes, illegal drugs are being introduced onboard ships and to overseas locations through the U.S. Mail. At the request of the Secretary of Defense and with the help of the Congress the U.S. Postal Service has moved to change Postal Regulations that required a Postal Inspector or court order from a Federal Magistrate prior to inspection of the mails. These changes have been pub-

lished in the Federal Register and will become effective by June 2, 1982, if no adverse comments are received. In the interim Navy is doing everything possible to make drug abuse not worth the risk of detection and disposition. Use of urinalysis testing, inspections, the Naval Investigative Service, Master-at-Arms law enforcement efforts and drug detection dogs are maintaining a full-court press. Onboard some ships dogs are posted in the passageway outside the post office and the number of packages being returned or not accepted is indicating that we are stemming the flow of illegal drugs. Access to contraband mail is essential to the Navy who must have immediate interdiction/prevention authority underway where no Federal Magistrate is available.

Senator JEPSEN. Are DOD programs aimed primarily at on-duty use? If so, does not that send the message that off-duty use is okay?

Dr. BEARY. Our programs may appear to be directed at on-duty use, but that is only because we have more control and access to troops while they are on duty. Urinalysis, for example, detects drug use without regard to on-duty or off-duty use and law enforcement efforts certainly make no distinction as to when an illegal drug is used. Make no mistake about our intentions, we oppose illegal drug use regardless of the type of drug or when and where it is used.

Senator JEPSEN. How do you identify drug abusers?

Dr. BEARY. Drug and alcohol abusers are identified in a number of ways. For drug abuse, the largest percentage are identified as a result of law enforcement and investigatory actions. A number of alcohol abusers are also identified in this manner as a result of drunk driving or other incidents. Many other alcohol and drug abusers are identified by their commanders or supervisors. As the training of commanders and supervisors improves and expands, more and more abusers are being identified by that means. Drug abusers are frequently identified as a result of urine testing. Since we have developed the capability to test for marijuana, as well as the other major drugs of abuse, this means of identification has been growing rapidly. A significant number of abusers are identified by self referral to treatment. Those who seek treatment often volunteer after they realize they no longer can take or leave the alcohol or the drugs. These four means; law enforcement, commander/supervisor identification, urine testing, and self referral, constitute the bulk of our identifications. A small number are also identified as a result of medical care and as a result of safety incidents.

URINALYSIS

Senator JEPSEN. Dr. Beary, urinalysis is a major tool in identification. What steps has DOD taken to assure that errors such as those made by the laboratory analyzing the samples for the D.C. police force do not happen to Service members?

Dr. BEARY. Urine samples are collected under direct observation. Specimen bottles are then capped and labeled with the individual's identifying data and secured until shipped. They are shipped by a secure means and secured again upon arrival in the laboratory. In the laboratory each sample remains labeled while it passes through the various processes. Correct identification of samples has been a concern of the DOD and the laboratories since the system was inaugurated in 1971. Chain of custody procedures have been refined for years and we are confident that we will not make the mistakes made by the commercial laboratory in question.

Senator JEPSEN. Is the test for marihuana analogous to breathalizer tests for alcohol?

Dr. BEARY. No. The test for marihuana is an immunoassay similar to that used for other drugs. It is complicated and must be confirmed in a laboratory. In addition, the marihuana test does not indicate the level of intoxication like a breathalizer; it merely indicates that marihuana has been used within the past 2 to 3 weeks.

Senator JEPSEN. Why are the tolerance levels for the marihuana test set so high?

Dr. BEARY. The cutoff level we have set for marihuana is one which we believe will detect about 95 percent of the urine samples positive for cannibis at that concentration, and which we can confirm. If set lower, the system would detect more positives initially, but the confirmation procedures would not be able to detect them, and confirmation is essential before the positive can be reported to the donor's unit.

Senator JEPSEN. Gentlemen, how can you be sure that the urine specimen evaluated as positive for drugs actually belongs to the donor? In other words, are there procedural safeguards to protect a Service member from false identification?

Dr. BEARY. We have issued chain of custody procedures concerning the collection of samples, packaging and shipping to a regional laboratory, and processing at the laboratory. I have already described the details of these procedures and I am confident that they virtually assure the elimination of false identification.

ARMY

General MITCHELL. Yes, each urine sample is collected under direct observation of an appropriate unit representative. The sample has the date, the service member's social security number, and a unit identification number printed on it. After a positive donor has been identified, a clinical evaluation and confirmation is conducted by a physician.

Senator JEPSEN. What drugs can be detected through urinalysis? Is each sample tested for all of these drugs? If not, why?

Dr. BEARY. The drugs which can be detected by urinalysis are: amphetamines, barbiturates, cannabis, cocaine, methaqualone, opiates, phencyclidine.

A laboratory usually tests each sample for five drugs. We do not routinely test for all seven drugs because to do so would overload the system, and some drugs are not used in all areas of the world. We study the drug prevalence situation in the various areas of the world and then prescribe the drugs for which each laboratory will test.

Senator JEPSEN. Dr. Beary, please describe the laboratory system. Are the laboratories operated by DOD or by the Services? Who determines the priority for testing?

Dr. BEARY. The Department of Defense drug testing program is a coordinated tri-service effort which uses the military services' urinalysis laboratories. The system is organized to make the maximum use of available resources. Accordingly the program is based on Department of Defense-wide considerations rather than on the individual considerations of the Military Departments. Insofar as laboratory testing is concerned the Department of Defense uses standardized testing methods, procedures and criteria. Responsibility for testing on a tri-service basis is accomplished through the equitable assignment of geographic areas of responsibilities to each Military Department by the DOD. The DOD determines and promulgates to the Military Departments the priorities for testing.

Senator JEPSEN. Gentlemen, does DOD use outside consultants to advise on technical matters regarding urinalysis?

Dr. BEARY. Yes. We recently cosponsored a seminar on drug testing procedures with Dr. Carlton Turner. The seminar included participants from NIDA, the DOD and a panel of distinguished civilian scientists.

ARMY

General MITCHELL. Yes. The most recent retained consultant for the Army is Dr. Sid Cohen from UCLA. He will be looking into, among other areas, urinalysis over the next year.

PORTABLE URINALYSIS EQUIPMENT

Senator JEPSEN. Gentlemen, how good is the portable urinalysis equipment? Why is the Department of the Navy more interested in this equipment than Army or Air Force?

NAVY

Admiral MULLOY. Navy believes that portable urinalysis equipment is an accurate presumptive screening device with enormous detection and deterrence potential. Throughout the Department of Defense and the Navy laboratory system there is a one year field test being conducted of this equipment, which is basically a comparison between the number of kit detections and the number of such detections which are confirmed as being valid using more sophisticated laboratory equipment. Quantitative results are still incomplete but preliminary findings are extremely encouraging. Other factors in the field test include evaluating the durability of the kit in a shipboard environment and assessing the problem of resupplying units with consumable reagents.

Results from portable urinalysis equipment cannot by themselves be used for legal action or discharge proceedings. Positive portable kit results must be confirmed by a certified DOD Drug Screening Laboratory.

The reason Navy is purchasing these kits at a much faster rate than the other Services is due to the fact that so many of our commands are afloat and cannot easily send specimens to shore based laboratories. Aboard ship a commander needs to be able to quickly determine whether or not a member of his crew is using drugs. For example should a commanding officer suspect a quartermaster about to take the helm of a ship underway alongside another is not ready for such a precise duty, he can order a urinalysis. If positive it can't be used for discharge and discipline, but can be used to put the man in treatment and surveillance. At sea, laboratory only results could take weeks. The kit prevents a potential accident, injury or damage. Ships are close-knit fighting units which, unlike shore-based units, have no ready means of acquiring personnel reinforcements and are always in a constant state of vigilance while underway. The portable urinalysis equipment provides an excellent method of not only detecting drug use but of deterring drug use.

ARMY

General MITCHELL. The Army is conducting its second test of the portable kits. Presently, we are waiting for the end of the test before further decisions are made.

DISPOSITION OF IDENTIFIED ALCOHOL AND DRUG ABUSERS

Senator JEPSEN. Gentlemen, what happens to a Service member once he or she is identified as an alcohol or drug abuser?

ARMY

General MITCHELL. Once the service members is identified he or she is sent for a screening interview with an alcohol or drug counselor. If the initial screening confirms alcohol or drug abuse, a rehabilitation team, composed of at a minimum, the individual, his or her commander, and the ADAPCP counselor, will recommend appropriate disposition of the case. Other members of the team may include the ADAPCP clinical director, a physician, a chaplain, social workers, a psychologist, or other community human resources personnel. Although the team provides a recommendation, the decision as to disposition rests with the individual's unit commander, who is under no obligation to comply with the recommendation of the team. In situations involving involuntary identification the commander may elect to initiate criminal proceeding against the offender.

NAVY

Admiral MULLOY. NAVOPs 172/81 and 178/81 outline Navy's policy regarding the disposition of drug abusers. New accessions are screened throughout their indoctrination and training regimen, and then randomly when they join fleet activities. Members are evaluated on a "whole person" concept; however, the key requirement for retention and treatment is potential for continued service. An individual identified as a drug abuser for the first time is given a second chance if he or she is recommended by the Commanding Officer as having potential for further useful service. Those not so recommended, and those who are identified a second time are discharged. Officers, officer candidates and midshipmen who—because of their special position of trust and confidence as leaders—become involved in drug abuse are normally separated at the first confirmed incident.

Members identified as alcoholics or alcohol abusers are also evaluated as to future potential, past performance, severity of their problem and amenability to treatment. Based on this evaluation they are either retained and rehabilitated or separated. As a broad leadership policy statement we want to get rid of the abuse, not the abuser.

AIR FORCE

ANSWER. Unit commanders must enter all members identified as a drug or alcohol abuser into the Drug/Alcohol Abuse Evaluation Process (DAAEP) or into the drug or alcohol rehabilitation program. The DAAEP gives the commander sufficient information to make decisions concerning rehabilitation entry. The purposes of the DAAEP are to assess the extent of a member's abuse involve-

ment and determine the appropriateness or structure of a rehabilitation program. Unit commanders also decide whether to initiate disciplinary, administrative, or reclassification action. These decisions, however, are separate from the decision to enter a member into the DAAEP or rehabilitation, and are based on the merits of each individual case. The DAAEP includes consultations by command, medical, drug abuse control and chaplain (optional) personnel. These personnel provide evaluation and recommendation inputs to commanders and with the unit commander formulate a disposition course for each abuser. Rehabilitation is reserved for those who truly need it; those whose use represents only a disciplinary problem are punished, provided awareness education, and returned to duty when appropriate. Repeat offenders, traffickers, addicts and those who do not respond favorably to rehabilitation are quickly disciplined and/or separated as appropriate.

TREATMENT AND REHABILITATION PROGRAMS

Senator JEPSEN. Describe your treatment and rehabilitation program.

Dr. BEARY. Department of Defense rehabilitative and referral services, provided to identified alcohol and/or drug abusers, meet the quality assurance standards established in DOD Instruction 1010.6. A copy of that instruction has been provided for the record. These standards cover staffing, program components and quality assurances criteria for the three types of services provided-referral services, nonresidential rehabilitation, and residential rehabilitation.

Residential rehabilitation is available for those whose primary diagnosis is alcoholism. One Navy facility works with drug abusers. All programs reflect a multidisciplinary, reality centered approach, are designed to meet fundamental client needs and include a plan for family involvement, when feasible. Intake procedures for this level of care involve a command consultation, a medical assessment and a social evaluation. Individual after care plans are designed to identify continued support and are forwarded to the nonresidential facility servicing the person's home command.

Nonresidential rehabilitation is available for those who abuse alcohol and/or drugs and is accomplished at the individual's home base. Dependent on the level of care needed, the individual may be provided individual therapy, group therapy and/or educational classes during off duty hours. The length and type of nonresidential rehabilitation care plan is determined by a clinical assessment and command consultation. To ensure adequate client care monitoring and client record maintenance; periodic random case evaluations are performed by each facility to review the original assessment, recovery plan, client progress and overall appropriateness of the services provided.

All DOD components offer referral services on a routine basis. Procedures are established by each component which specifies the mechanism by which and the conditions under which referrals are made. A complete list of available rehabilitation and community support services is maintained by each facility.

Staff members for all three types of services provided are under the supervision of persons qualified to evaluate their performance and are given the opportunity to continue their professional growth and development. They are assigned in numbers sufficient to ensure program effectiveness. Staff members comply with the confidentiality requirements of Public Law 93–282 when conducting case evaluations, reviews and program monitoring.

August 12, 1981
NUMBER 1010.6

Department of Defense Instruction

ASD(HA)

SUBJECT: Rehabilitation and Referral Services for Alcohol and Drug Abusers

References: (a) DoD Directive 1010.4, "Alcohol and Drug Abuse by DoD Personnel," August 25, 1980
(b) Public Law 93-282, "The Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974 (88 Stat. 125)

A. PURPOSE

This Instruction states the DoD rehabilitation and referral services policy in execution of reference (a).

B. APPLICABILITY

The provisions of this Instruction aprly to military personnel and civilian employees of the Office of the Secretary of Defense, the Military Departments, the Organization of the Joint Chiefs of Staff, the Unified and Specified Commands, and the Defense Agencies (herein referred to as "DoD Components").

C. DEFINITIONS

1. Detoxification. Planned management of the alcohol and drug withdrawal processes. Medical detoxification is accomplished on an inpatient basis and includes withdrawing alcohol and other drugs of abuse from the individual and providing indicated medical and psychological support.

2. Rehabilitation. The process of restoring to effective functioning persons impaired by the use of alcohol or drugs.

3. Residential Rehabilitation. Rehabilitative services provided on a 24-hour, live-in basis for those who abuse alcohol or drugs.

4. Nonresidential Rehabilitation. Rehabilitative services provided on a nonlive-in basis for those who abuse alcohol or drugs.

5. Referral. Information and/or assistance provided to those who abuse alcohol or drugs for locating appropriate rehabilitative services, ancillary services, or community support groups.

6. Rehabilitation Personnel. Trained members of the alcohol and drug abuse program staff qualified to provide consultative, rehabilitative, or referral services.

7. Support Staff. Members of an alcohol and drug abuse rehabilitation or referral program whose primary work activities involve clerical, housekeeping, security, laboratory, recordkeeping, or other nonmanagerial functions necessary for the overall clinical and administrative operation of the program.

D. POLICY AND PROCEDURES

1. It is the policy of the Department of Defense to be free from the effects of alcohol and drug abuse to maintain high standards of performance, military discipline, and readiness. Therefore, the Department of Defense shall rehabilitate the maximum number of those who abuse alcohol or drugs by providing quality-assured residential, nonresidential, consultative, and/or referral services to such individuals and, when feasible, to their family members.

2. Specific policy guidance shall be developed by DoD Components for each of the following services, when they are provided.

a. Residential Rehabilitation

(1) Staff

(a) DoD Components shall develop criteria that determines the minimum number of appropriately trained professionals, rehabilitation personnel, and support staff required to ensure program effectiveness.

(b) Staff members shall be under the direct supervision of a person qualified to evaluate their performance.

(c) Staff members shall be afforded the opportunity to continue their professional growth and development.

(2) Program

(a) Therapeutic Concept. The program's philosophy of residential rehabilitation shall reflect a multidisciplinary, reality-centered approach.

(b) Program Entry and Termination Criteria

1 Criteria shall be established to determine the eligibility of clients for admission. Intake procedures shall involve a command consultation, a medical assessment to include the type of detoxification required, and a social evaluation that identify the client as requiring rehabilitative services appropriate to the level of care provided at the residential facility.

2 Criteria for termination of residential services shall be established and incorporated in the initial rehabilitation plan.

(c) Clinical Support Services. There shall be a written plan to describe the provision and organization of clinical support services to meet identified client needs, such as, physical and psychological assessment, medical support, nutritional guidance, and physical conditioning.

(d) Program Components. Program components shall be designed to meet fundamental client needs. Documentation of initial and ongoing assessment shall include assessment of these needs.

(e) Family Involvement. Initial client assessment shall include family data. A plan for family involvement in rehabilitation shall be included when feasible.

(f) Aftercare. Programs shall include an individualized plan designed to identify continued support of the client. This plan shall be forwarded to the nonresidential facility servicing the command to which the client is assigned.

(3) Quality Assurance

(a) To ensure adequate client care monitoring there shall be individual case review. The residential rehabilitation care planned and provided shall be updated according to the needs of each client. In addition, supervisory and consultative personnel shall schedule regular, periodic, or random case evaluations to review the original diagnosis, recovery plan, progress of the client, and overall appropriateness of the rehabilitation services provided.

(b) To ensure adequate client record maintenance, client records shall be reviewed periodically by supervisory and appropriate consultative personnel. The care provided shall be accurately documented in a complete, timely, and appropriate manner.

(c) Case evaluations and reviews shall be in compliance with the confidentiality requirements of P.L. 93-282 (reference (b)).

b. Nonresidential Rehabilitation

(1) Staff

(a) DoD Components shall develop criteria that determine the minimum number of appropriately trained professionals, rehabilitation personnel, and support staff required to ensure program effectiveness.

(b) Staff members shall be under appropriate supervision.

(c) Staff members shall be afforded the opportunity to continue their professional growth and development.

(2) Program

(a) Therapeutic Concept. The program's philosophy of nonresidential rehabilitation shall reflect a multidisciplinary, reality-centered approach.

(b) Program Entry and Termination Criteria. Criteria shall be established to determine the eligibility of clients for entry. Intake procedures shall involve a command consultation and a clinical assessment that identify the appropriate rehabilitative services required. Criteria to be met for termination of nonresidential services shall be established by DoD Component policy. The appropriate commanding officer, in conjunction with the rehabilitation staff, shall determine the length of the individual's rehabilitation program.

(c) Program Components. Program components shall be designed to meet fundamental client needs. Documentation of initial and ongoing client assessment shall include consideration of these needs.

(d) Family Involvement. Initial clinical assessment of the identified client shall include family data. Family involvement in rehabilitation shall be included when feasible.

(e) Post Rehabilitation. Programs shall assist the individual in developing a continuing support plan.

(3) Quality Assurance

(a) To ensure adequate client care monitoring there shall be individual case review. The nonresidential rehabilitation care planned and provided shall be updated according to the needs of each individual client. In addition, supervisory and consultative personnel shall schedule regular, periodic, or random case evaluations to review the original assessment, recovery plan, progress of the client, and overall appropriateness of the rehabilitation services provided.

(b) To ensure adequate client record maintenance, client records shall be reviewed periodically by supervisory and appropriate consultative personnel. The care provided shall be accurately documented in a complete, timely, and appropriate manner.

(c) Case evaluations and reviews shall be in compliance with the confidentiality requirements of P.L. 93-282 (reference (b)).

c. Referral Services

(1) Staff

(a) Programs shall have a sufficient number of staff trained in problem assessment and referral.

(b) Technical supervision and assistance shall be made available to the staff.

(c) Staff members, to include civilian additional duty personnel, shall be afforded the opportunity to continue their professional growth and development.

(2) Program

(a) Guidelines

1 Component programs shall offer referral services on a routine basis.

2 Procedures shall be established that specify the mechanism by which and the conditions under which referrals are made.

3 There shall be documentation of the number of individuals screened and the type of referrals made.

(b) Client Assessment. Client assessment shall determine the need for further assessment or rehabilitation services.

(c) Referral Resources. A complete list of available rehabilitation and community support services shall be maintained.

(d) Follow-up. A plan shall be established to obtain a follow-up report from the receiving agency within a designated period of time.

(3) Quality Assurance. Periodic reviews shall be conducted to evaluate the quality and completeness of intake activities, the appropriateness of the referral, follow-up actions and, to the extent possible, the quality of care provided by the referral resource. Follow-up actions and reviews shall be in compliance with the confidentiality requirements of P.L. 93-282 (reference (b)).

d. Program Evaluation

(1) An evaluation program shall be established to measure the extent to which services provided meet organizational needs, program goals, and objectives.

(2) All aspects of rehabilitation and referral systems shall be evaluated to determine program effectiveness and proper allocation of resources.

E. RESPONSIBILITIES

Heads of DoD Components shall implement the intent and standard of this Instruction.

1010.6
Aug 12, 81

F. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

Assistant Secretary of Defense
(Health Affairs)

96-562 O - 82 - 8

ARMY

General MITCHELL. The objectives of the rehabilitation program are. For military personnel: first, restore individuals identified as alcohol or other drug abusers to effective duty. Second, identify individuals who cannot be rehabilitated and refer them for separation from the Army. For civilian employees, restore those with job performance problems related to alcohol or other drug abuse to effective performance. For civilian family members of military and civilian employees, resolve alcohol and drug abuse problems in the family with the ultimate goal of enabling the service member or employee to perform more effectively by being able to devote full time and attention to the job.

Three levels, or "tracks", exist in the rehabilitation system. Track I provides alcohol and other drug awareness education, and individual or group counseling or assessment as required. The education and discussion effort is designed to focus the client's attention on the adverse effects and consequences of alcohol or other drug abuse, and emphasizes Army policy regarding alcohol and drug abuse. Track I usually is limited to 30 days; the client will be transferred to one of the remaining tracks or will be referred to another resource or agency if more intensive rehabilitation efforts are indicated.

Track II provides individual, group, or family counseling on an outpatient basis; the educational services of Track I are available in addition to this intensive counseling effort. Enrollment in Track II will be for a minimum of 30 days, and will not to exceed 360 days. The client may be transferred to Track III, or referred to another resource for additional services, if required.

Track III provides an intensive residential-inpatient-treatment of six to eight weeks duration with an outpatient follow-up phase for a total treatment period of one year. The inpatient phase is conducted within a military medical treatment facility. Track III is designed for clients who do not respond favorably to outpatient counseling or who have become dependent on alcohol or other drugs.

The ADAPCP utilizes a variety of multidisciplinary treatment modalities within the three tracks. These include: preventive education; individual counseling; group counseling; pharmacotherapy—excluding methadone maintenance; Alcoholics Anonymous, and allied AA family groups; physical training; and recreational therapy.

These treatment modalities are available to ADAPCP worldwide, as are both inpatient and outpatient services. Each client's rehabilitation plan is developed on a case-by-case basis, and includes one or more of these modalities.

NAVY

Admiral MULLOY. During dependent members identified by their commanding officers as having potential for further useful service are sent to the Naval Drug Rehabilitation Center, Miramar, CA for a 7-week rehabilitation program. Alcoholic members receive a six-week rehabilitation program at one of three large Alcohol Rehabiliation Centers, or at one of 24 Alcohol Rehabilitation Services in Naval Hospitals. Less severe cases of drug or alcohol abuse receive counseling at one of more than 60 Counseling and Assistance Centers located aboard larger ships or at naval bases in major Navy population centers. For those judged not to be dependent primary initial treatment and counseling is given at the unit level for the majority of abusers.

AIR FORCE

ANSWER. Both outpatient and inpatient treatment/rehabilitation programs are offered by the Air Force. Outpatient drug and alcohol rehabilitation programs are available at over 125 Air Force installations. Inpatient detoxification and other abuse-related medical treatment are also provided by Air Force hospitals. Inpatient alcoholism treatment is provided at ten Air Force Alcoholism Rehabilitation Centers (ARCs). ARC programs are 28-day, medically supervised, multi-modality programs. Standard inpatient programs include group counseling sessions, individual counseling, education about alcohol, recreational and occupational therapy, relaxation therapy, and health counseling. Both drug and alcohol rehabilitation/treatment programs include aftercare. All these clinical options are available to Air Force personnel worldwide.

EFFECTIVENESS OF TREATMENT AND REHABILITATION

Senator JEPSEN. Is it effective? Has it been evaluated? Why do not the Air Force and Army operate residential treatment programs for drug abusers like the Navy's center at Miramar?

Dr. JOHNS. No, we have not evaluated our programs scientifically. The fact that two former Presidents sent relatives to one of our facilities speaks well for the services being offered. We do need more precise data, however, and for that reason my staff is in the process of preparing a request for proposals to conduct such an evaluation. We expect to initiate the project by late fall.

ARMY

General MITCHELL. The Army does not feel that the military environment is conducive to long term rehabilitation for drug dependents. The Army's residential treatment programs do treat drug dependents as well as poly drug and alcohol abusers.

NAVY

Admiral MULLOY. Yes, the Navy alcohol and drug rehabilitation programs are very effective. Independent evaluation of the Navy's alcoholism treatment modality, for example, shows an overall $2 savings per dollar expended when all alcoholic service members are treated and successfully rehabilitated and retained, vs discharging them and bringing in and training new replacements. The cost benefits are even higher—$5 saved per dollar expended—when one considers only the rehabilitation of career service members 26 years of age and older. Although the cost benefits of the drug program are not as great from a dollar point of view, the identification and screening out of traffickers and hard core recalcitrants involved in illegal drug activities are invaluable services performed by this program. The large majority of drug abusers are young first term members with limited Navy experiences, and the savings resulting from their rehabilitation and return to duty cannot be expected to offset the high cost of law enforcement and large scale urinalysis testing including expensive laboratories and portable kits.

AIR FORCE

Answer. Yes. The Air Force Treatment and Rehabilitation Programs have been most effective in arresting chemical abuse and restoring members to effective functioning through outpatient treatment programs. Our programs have been successful because they emphasize compliance with Air Force standards and ongoing command, drug/alcohol and medical personnel support. A recent Rand study confirmed the cost effectiveness of our outpatient alcohol treatment and rehabilitation model. Each Major Command (MAJCOM) has a drug/alcohol abuse control staff that manages and monitors the MAJCOM and field unit drug abuse control program. These MAJCOM staffs and the Social Actions Management Division, HQ Air Force Military Personnel Center, Randolph AFB, TX, provide additional program monitoring through staff assistance visits. Formal program evaluations are conducted periodically through MAJCOM Inspector General activities. With regard to drug abuse, it is Air Force policy to separate drug dependent members. Limited hospitalization is provided to drug abusers as needed and outpatient behavior modification treatment programs are provided to those drug abusers determined to possess good potential for retention in the Air Force.

COUNSELOR TRAINING

Senator JEPSEN. What kind of training do your counselors receive?

Dr. JOHNS. Entry level training programs which qualify counselors to function in alcohol and drug abuse residential or non-residential rehabilitation facilities are 8–10 weeks in length. General subject areas which include interpersonal communications, personality development, human behavior, group dynamics, treatment applications and program management are addressed in didactic classes and practical exercises. Students are evaluated based on their performance in practicums and written examinations. The Services differ somewhat in their approaches, however, all counselor graduates have received good training.

ARMY

General MITCHELL. The majority of Army enlisted personnel serving as counselors in the ADAPCP hold the MOS of 91G, Behavioral Science Specialist. After completion of basic training, service members then complete the Advanced Individual Training; the 91G course provides 16 hours of training directly related to alcohol and other drug abuse.

After completion of the 91G training, those selected for assignment as ADAPCP counselors complete an additional four weeks of instruction as students in the United States Army Drug and Alcohol Rehabilitation Training course, at the Academy of Health Sciences, Fort Sam Houston, Texas. The first two weeks are spent focusing on individual counseling skills; the second two weeks are devoted to developing group counseling skills.

NAVY

Admiral MULLOY. Navy Alcoholism Treatment Specialists receive a 10 week course at the Alcohol Rehabilitation Center, San Diego, CA followed by one year of practical training in a rehabilitation facility prior to certification. Navy Drug and Alcohol Abuse Counselors also receve a 10 week course at the Naval Drug Rehabilitation Center, Miramar, CA. At a few locations each year, counselors who have served on board for a year or more receive post graduate perceptor training to sharpen their skills. All hands now receive education on substance abuse at each accession training activity, at all subsequent training pipeline schools and in unit level mandatory leadership related training.

AIR FORCE

ANSWER. Drug/Alcohol Abuse Control Specialists receive 320 hours of training. The training program is conducted at Lackland AFB, Texas and provides instruction in the following areas: 42 hours of teaching techniques/practice teaching; 41 hours of educational background material; 76 hours of fundamentals in education, counseling, and management; 112 hours of specific counseling skills; 42 hours of program management; and, 7 hours of research/independent study. Upon satisfactory completion of this course, the graduate is awarded a drug/alcohol abuse control specialist code 73430B. Further skill development is provided through on-the-job training which includes supervision and observation, and prescribed specialist studies (Career Development Courses). Many drug/alcohol abuse specialists are sent to the Johnson Institute, Minneapolis, MN. for a three-week chemical dependency training course. Additionally, the family counseling skills of selected drug/alcohol specialists were recently upgraded via family and chemical dependency workships conducted by the Howard Family Institute.

DRUG AND ALCOHOL ABUSE CAREER FIELD

Senator JEPSEN. Why is the Air Force the only Service with a drug and alcohol abuse career field? Why has not the Secretary of Defense ordered the other Services to do this?

Dr. JOHNS. I think that the Air Force social action career field has definitely enhanced their overall drug and alcohol prevention capability. I have encouraged each of the other Services to look at the career field as a possibility, but in this instance there are a number of Service specific variables which must be considered. These variables and this decision are best evaluated by the individual military services. I strongly support the career field concept however, and believe the other Services will eventually adopt it in some form.

ARMY

General MITCHELL. The Army personnel management system does provide for enlisted counselors as behavioral science specialist—91G—with additional training in drug and alcohol counseling. The officers working in the program come from the personnel management and behavioral science career field. The Army believes this provides the desired balance between command and clinical personnel.

EDUCATING TROOPS ABOUT DRUG DANGERS

Senator JEPSEN. What steps has DOD taken to educate the troops about the dangers of substance abuse? There is a lot of new information about the damage

caused by marihuana use. Has DOD done anything to get this information out, particularly to the young enlisted force?

Dr. JOHNS. We have taken a number of steps to educate the troops about the dangers of marihuana. The American Council on Marihuana has prepared a pamphlet for us targeted to the 18–25 years old on the myths and facts about marijuana. Through funds provided by the American Forces Information Service (AFIS), we have purchased approximately 100,000 copies of this pamphlet. We have also worked closely with AFIS in publishing articles in a popular publication called Soldier, Sailor, Airman, Marine (SSAM) on the dangers of marijuana. In addition, the Education and Training Subcommittee chaired by a member of my staff is currently reviewing new pamphlets on marijuana for use in our education programs. We intend to continue providing the latest scientific information about the dangers of marihuana use to our troops. We are also planning a media campaign for troops stationed outside the continental United States that features both radio and television spot announcements on the facts about marijuana.

ARMY

General MITCHELL. Alcohol and drug abuse education is targeted for specific groups generally based on grade and level of responsibilities rather than age.

Trainees receive prevention awareness education during initial entry training. Included are disciplinary, career, and health consequences of substance abuse. The trainees are made aware of available counseling and treatment resources, and procedures and alternatives to abuse. The number of instruction hours varies by installation.

In addition to training during initial entry and service school attendance, service members in grades E1 through E4 are required to receive alcohol and drug abuse education within 60 days after each permanent change of station —PCS—. This training emphasizes the legal consequences of abuse under both the UCMJ and local laws. Emphasis is also placed on the availability of an ADAPCP at the installation to include location, referral procedures, and types of treatment available. Alternatives that are available at the local installation and neighboring communities are stressed during this training.

Junior officers and warrant officers also receive education within 60 days after PCS regarding the command unique elements of the alcohol and drug abuse problem and local military and civilian resources. Emphasis is also placed on the availability of an ADAPCP to include location, leader's responsibilities in the identification and referral process, opportunities for continuing education and training, and responsibilities for maintenance of military discipline and enforcement of the Uniform Code of Military Justice.

In addition, both enlisted and officer personnel receive periodic alcohol and drug abuse prevention instruction conducted by local commands.

The United States Military Academy. Cadets receive one to four hours of alcohol and drug prevention education per year. Topics covered include responsible drinking, alcoholism, drinking and driving, military police support, use of marihuana dogs, AR 600–85, impact on morale, discipline and readiness, responsibilities of leaders.

Reserve Officer Training Corps—ROTC. There is no mandatory requirement for training in drug abuse issues in the ROTC curriculum. Some regions and schools have elected to include drug and alcohol abuse prevention in their programs. Recently, the US Army Drug and Alcohol Technical Activity conducted training for cadets at North Georgia College.

Officer Candidate School. Training is required with emphasis on awareness of policy, leadership role, and Army alcohol and drug abuse prevention and control programs.

Command and General Staff College. Students receive from two to four hours of alcohol and drug abuse training as part of their study of contemporary issues. Additionally, attendees at the Army's pre-command course—05 and 06—receive two hours of alcohol and drug related training. Topics include the need for command support, law enforcement issues and prevention aspects of the problem.

War College. Instruction in drug and alcohol abuse is addressed in context with specific subject areas such as readiness or exercises. For example, drug abuse may be addressed when students consider problems facing commanders.

Non-Commissioned Officer Academies. The number of hours and content of instruction varies by school. Emphasis is placed on the role and responsibilities

of leaders for deterrence and detection, identification of problems, and the impact of alcohol and drug abuse. The Sergeants Major Academy provides four hours of instruction.

Other leadership schools and programs. The number of hours and content of instruction varies by school. For individuals with primarily first-line supervisory responsibilities, education focuses on identification and strategies for deterring drug use. For officers and noncommissioned officers with command or management responsibilities, education focuses on strategies a senior leader can employ to create a command or unit environment which will prevent alcohol and drug abuse and encourage those with problems to seek treatment.

EVALUATING THE PREVALENCE OF DRUG ABUSE

Senator JEPSEN. Does DOD have a mechanism to evaluate the prevalence of drug abuse in the military? Do you get information about deaths, accidents, etc., due to alcohol or drug abuse? How do you monitor drug trends?

Dr. BEARY. The Office of Drug and Alcohol Abuse Prevention (ODAAP) operates a comprehensive reporting system with the Services and Defense Agencies and periodically conducts world-wide substance abuse prevalence surveys to analyze and monitor trends.

The ODAAP reporting system has been steadily expanded and improved since the early 1970's and currently includes eight reports, the majority of which are submitted quarterly. Information is obtained from a variety of sources, such as medical, law enforcement, recruiting, and urinalysis testing laboratories. Information on deaths and accidents is provided in most cases, except that aircraft mishaps are investigated and reported in a very prescribed manner which does not directly involve ODAAP. This management information and reporting system is being revised to provide a more refined analysis of the nature and costs of accidents involving drug and alcohol abuse and civilian employee assistance programs.

This year three prevalence survey initiatives are in progress. A survey will be administered to a representative sample of civilian employees from June through September. The second iteration of a worldwide military personnel drug and alcohol abuse survey will be conducted in the fall. High school seniors at thirty DOD Dependent Schools were recently surveyed as part of a national study, "Student Drug Use in America" which has been conducted annually since 1975.

DOD CIVILIAN DRUG ABUSE

Senator JEPSEN. Dr. Beary, what is the extent of alcohol and drug abuse among DOD civilian employees? Do you have programs for DOD civilians? If so, how good are they? Are they the same as those for the military? If not, how do they differ?

Dr. BEARY. We have no reason to believe that alcohol and drug abuse rates among Department of Defense civilian employees are any different from those found in the general population. However, because we are concerned and want to have a better understanding of the extent of this problem, the Department is presently involved in a survey of civilian employees, similar to the one done for military personnel in 1980. The survey should provide a more precise answer to this question. We expect to have completed survey results this winter.

The DOD has provided alcohol and drug abuse prevention programs since 1971 in accordance with the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (Public Law 91-616). Each of the military services and Defense Agencies is required by DOD Directive 1010.4 to provide programs for civilian personnel that comply with public law 91-616 and 92-255 as well as instructions from the Office of Personnel Management.

The programs for civilian personnel within the Department vary according to the resources applied. However, all military Services and Defense Agencies operate programs which provide services to civilian employees. As a whole, DOD programs are better than those found in most Federal Agencies, but we are not completely satisfied and are in the process of evaluating the present level of effort in this area. In general we have not provided civilian programs the priority or resources that we have for our military programs. We intend to change this situation according to the extent of the problem as determined by the survey.

Civilian programs differ from military programs in several key areas. First, an intervention with civilian employees is initially predicated on job performance.

Additionally, civilian employees cannot be required to enter a treatment program. There are no residential treatment programs operated by DOD for civilian employees; we must depend on the employee's health benefits to cover costs associated with rehabilitation. Urinalysis is presently not used as an identification tool because of questionable legal problems associated with its use with civilian employees.

The Department recognizes that a wide range of problems not directly associated with job performance may have an adverse effect on an employee's ability to function effectively. In many instances the employee is aware of these problems and able to take the necessary corrective action with a negligible impact on performance. In some cases, however, neither the employee nor supervisor is able to correct the problem without outside assistance.

For these cases the Department of Defense has established a management and employee assistance office called the Pentagon Employee Referral Service (PERS). The goal of this project is to assist supervisors and employees in achieving optimal job performance through resolution of the presenting problem(s). PERS services include acceptance of referrals, problem evaluation, referral to appropriate community treatment resources, monitoring employee progress, supervisory consultations, and providing appropriate education and training classes.

The success of this program is well known throughout the Federal Government and we have been repeatedly called on by other Federal Agencies to assist them with cases involving alcoholics at the executive level. After the first nine months of operation the PERS had more than 300 referrals with problems ranging from personality conflicts to spouse abuse, but the single most common referral was for alcohol/drug abuse.

REDUCING OPIATE ABUSE

Senator JEPSEN. Dr. Beary, DOD has apparently done a good job in reducing the levels of opiate abuse, but the use of alcohol and marihuana is still very high. How long do you think it will take to get these problems under control?

Dr. BEARY. As I previously stated, I think the new legal and scientific tools we have will enable us to reduce the high level of cannabis use. However, it will take more than legal action to make lasting inroads against cannabis use. We must change the attitudes of our young people about marihuana through education and improved unit cohesion. Like the anti-smoking campaign, this will be a long term process. We can expect a steady but gradual reduction in the prevalence of cannabis use, but we should not expect dramatic, short-term results. Cannabis use cannot be eliminated overnight.

RETURN TO DRAFT

Senator JEPSEN. Would a return to the draft help to reduce drug abuse in the military?

Dr. BEARY. No, it would not. Surveys conducted annually by the National Institute on Drug Abuse report that 46 percent of high school seniors have used marihuana in the past year, 32 percent in the past month and that 7 percent are daily users. It is clear from the NIDA survey that a significant number of our nations youth are experienced drug users. Whether in an all volunteer or draft environment, the military simply cannot screen out everyone who has ever used an illicit drug.

LAW ENFORCEMENT

Senator JEPSEN. Dr. Beary, what law enforcement efforts have been initiated by DOD to reduce drug abuse?

Dr. BEARY. Drug law enforcement in the Department has been increased substantially, beginning in late 1978. First, drug law enforcement was expanded in the European Theatre during 1979 to 1981. Law enforcement manpower was substantially increased, drug detector dogs were increased by over 200 percent, and a Special Assistant for Drug Enforcement Matters (SADEM) was established to coordinate law enforcement activities in the European Command.

Emphasis in the U.S. and other regions of the world has also continued to expand. Army Criminal Investigation Command drug suppression activities have been successful in interdicting drug possession and trafficking. The Army seized about $180 million worth of illicit drugs during 1981, one third increase over 1980.

The Navy has established four forensic laboratories to improve criminal investigatory capacity. Naval Investigative Service (NIS) narcotics investiga-

tions (Navy and Marine Corps) during 1981 increased by 40 percent over 1980. It appears that 1982 will show a further increase. NIS has added 185 more agents since late 1980. Use of drug detector dogs is increasing regularly.

Air Force law enforcement programs, including the Office of Special Investigations and the Security Police, have remained active. Sale and trafficking investigation rates have tripled since 1978. The Air Force trains most of the drug detector dogs used by the Services, and they have increased their training rate.

Emphasis on drug law enforcement is strong and will remain so in the Department of Defense. It remains the primary method of identification of drug abusers and the main means of taking illicit drugs out of circulation.

PRESERVICE DRUG USE

Senator JEPSEN. What is the DOD policy on pre-service drug use? Are you able to keep all those who have used drugs from entering the military?

Dr. BEARY. The Department of Defense will not induct alcohol or drug dependent members. The Secretaries of the military departments establish procedures to insure that they are not inducted. Procedurally, the local recruiter has each applicant complete a medical prescreening form, which asks if the applicant has an addiction to drugs or alcohol. If the applicant indicates addiction, the recruiter discourages further processing. In questionable cases, the prescreening form and the available documentation regarding the addiction are sent to the Medical Officer at the Military Entrance Processing Station (MEPS) for a decision as to whether the applicant should be sent to the MEPS for a complete medical examination. At the MEPS, all applicants receive a personal medical history interview with a physician, who reviews their prescreening form and their SF Form 93 (Report of Medical History). If any alcohol or drug abuse is indicated, the physician questions the applicant thoroughly regarding the abuse. If the drug abused is marihuana, LSD, PCP or alcohol, the physician determines underlying evidence of psychopathology or personality disorder. He looks at the applicant's appearance and behavior in the MEPS and his school, work, legal and psychiatric history. Questionable cases are referred to a psychiatrist for evaluation. If there is no associated/significant psychopathology, the applicant is qualified for entry and is referred to the service for which he is applying to determine administrative acceptance. If the physician finds that the applicant has used opiates, amphetamines, or barbiturates within the past year, he is medically disqualified and may not enlist. If use was more than one year ago, further medical evaluation, including a search for evidence of recent use, such as needle marks, is performed. If there is no evidence of continuing use and/or current psychopathology, the applicant is found medically qualified and is referred to the service to determine administrative acceptance.

These procedures by no means keeps all those who have used drugs from entering the military. It would be virtually impossible to do so. We know from national surveys that nearly two-thirds of the high school seniors of America have used an illicit drug. About one-third are current users of marihuana. Use among non-high school graduates is thought to be even higher. Many of these young people use drugs occasionally, and no medical or behavioral symptoms which could be recognized during a physical have appeared at this point in their lives. The Department simply could not refuse to accept anyone who has ever used drugs. We could not begin to meet recruiting goals if we ruled out sixty-five percent of our recruit-age population. Moreover, even if we made such a ruling, we could not enforce it because past use of illicit drugs could not be detected in the vast majority of cases. However, it is made clear to those entering the military that drug use is not tolerated.

ARMY

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abused is marihuana, LSD, PCP or alcohol, the physician determines underlying evidence of psychopathology or personality disorder. He looks at the applicant's appearance and behavior in the MEPS and his school, work, legal and psychiatric history. Questionable cases are referred to a psychiatrist for evaluation. If there is associated-significant-psychopathology, the applicant is medically disqualified and may not enlist. Otherwise, he is found medically qualified and is referred to the service for which he is applving to determine administrative acceptance. If the physician finds that the applicant has used hard drugs—opiates, amphetamines, barbituates—within the past year, he is medically disqualified and may not enlist. If use was more than one year ago, further evaluation, including a search for evidence of recent use, is performed. If there is no evidence of continuing use and of current psychopathology, the applicant is found medically qualified and is referred to the service to determine administrative acceptance. Generally, an otherwise qualified applicant is accepted for enlistment in the Army if there is no indication of drug abuse within the previous year. However, if the applicant has a criminal record reflecting the possession or use of drug or alcohol, to include marijuana, a moral waiver must be approved before the applicant can enlist. Further, any court conviction for selling or trafficking in marihuana or harmful habit-forming drugs is a non-waivable disqualification. Additionally, the following documents are the minimum required to request a waiver for substance abuse. First, favorable reports from a probation or parole officer which show that the applicant has performed satisfactorily while in a probation or parole status. Second, favorable reports from correctional facility officers.

DRUG ABUSE BUDGET

Senator JEPSEN. What is the DOD alcohol and drug abuse budget for fiscal year 1983? Is more or less money being spent than in the past on this problem?

Dr. BEARY. The total Defense Department fiscal year 1983 budget for drug and alcohol abuse control matters is $142.708 million. This is more money than has been spent on this problem anytime in the past.

SUBSTANCE ABUSE

Senator JEPSEN. What research is currently being conducted by DOD regarding substance abuse? Why is not more being done in this area?

Dr. BEARY. The Department of Defense is engaged in minimal drug and alcohol abuse research because the Congress in 1976 decided that the DOD should not engage in any substance abuse research that was not specifically military. Research is to be accomplished by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. The Army is conducting some research on the effect of drug and alcohol abuse on tank crew cohesion and the Navy is cooperating with NIAAA on a project studying the determination of alcoholism through blood chemistry studies.

NIDA AND NIAAA

Senator JEPSEN. Does DOD maintain a close working relationship with NIDA and NIAAA? If so, what are some specific examples of this cooperation?

Dr. JOHNS. Yes, we work very closely with both NIDA and NIAAA. I serve as a member of the National Advisory Council of both institutes. We have worked together on improving methods for detecting alcoholism and illicit drug use, we use the education materials produced by the two clearinghouses in our programs and we participate in each others conferences and workshops.

CONCERN AT TOP LEVELS OF COMMAND

Senator JEPSEN. Has the Secretary of Defense taken a personal interest in the drug and alcohol abuse problem? Do you have adequate access to the Secretary and Deputy Secretary of Defense? Has personal concern been shown at the top levels of command in the Services?

Dr. BEARY. Both the Secretary of Defense and his Deputy have been and continue to be very supportive in our efforts regarding substance abuse in the DOD. Dr. Johns and I have given them regular briefings on our progress and on key issues. Moreover, directives establishing DOD policy on drug and alcohol abuse are signed by the Deputy Secretary of Defense. To further emphasize the commitment to our program, the position of Special Assistant for Drug Abuse was elevated to the Deputy Assistant Secretary level.

The Secretary of Defense himself has charged the service secretaries and chiefs to give personal attention to this problem. Judging from recent policy changes and command emphasis, the Services have responded well to the Secretary's guidance.

ARMY

General MITCHELL. As I stated in my opening remarks the Chief of Staff of the Army and Secretary of the Army have demonstrated their personal concern about the Armys alcohol and drug problem.

NAVY

Admiral MULLOY. Yes. The Chief of Naval Operations, Admiral Thomas B. Hayward, was featured in a 15-minute videotape in which he discussed quite frankly the Navy's policy on drug abuse. This videotape was first presented in December 1981 to all Flag officers in San Diego, Norfolk and Washington, D.C. representing the majority of Flag officers in the Navy and personally attended by both the Atlantic and Pacific Fleet Commanders in Chief. Those briefings lasted eight hours each and covered the policy, legal, substance abuse identification, impacts and treatment requirement by the Navy's foremost experts in the field. Subsequently this videotape has been shown Navy-wide and is featured on a regular basis as part of indoctrination training and general training on drug abuse.

Admiral Hayward's message was quite clear. Drug abuse is unacceptable in the United States Navy and will not be tolerated. Members are encouraged to seek "help" which will be given. But if they persist in abusing drugs, when identified, they will be "hammered."

ALCOHOL AND DRUG ABUSERS ENTERING OR IN PRP

Senator JEPSEN. What special precautions are taken to assure that personnel who abuse drugs or alcohol do not enter or remain in PRP or other sensitive programs?

Dr. BEARY. As part of the Personnel Reliability Program (PRP), individuals are screened by investigative background checks, physical exams, record reviews, and commander interviews. Performance and reliability of the individuals are continually reviewed and recertified by commanders.

These Personnel Reliability Program protections are only one layer of a multilayered safeguard system. Two man policies and special protective devices are also part of the safeguard system. Nuclear weapons are designed with safety and security features to provide protection against inadvertent prearming or arming of nuclear components in both normal and abnormal environments. In addition, nuclear weapons are quipped with permissive action link (PAL) devices which are included in or attached to the weapon system to preclude arming and/or launching until the insertion of a prescribed discreet code or combination. Granting of clearances is thorough. Any use of hallucinogenic drugs (past or present) results in automatic and permanent removal. A past history of drug experimentation (other than hallucinogens) is reviewed on a case-by-case basis for possible qualification, but strong evidence of current non-use and a stable life-style must be present. Current drug use results in disqualification. Even persons who use prescription drugs which have any possibility of causing disorientation are temporarily suspended until medication is completed.

ARMY

General MITCHELL. A history of pre-service drug abuse is disqualifying for nuclear duty—PRP—training or assignment. However, in accordance with announced DOD policy on cannabis use, a history of limited—isolated or experimental—pre-service personal use of cannabis is not disqualifying for PRP. Nevertheless, an individual who admits limited cannabis use during the 90 days immediately preceding application for enlistment or appointment for training or assignment in nuclear weapons skills or positions must sign a request for a waiver of such recent limited use and agree in writing to desist from cannabis use if enlisted or appointed. PRP training or assignment is not available to any applicant for enlistment or appointment who has been convicted of cannabis use or possession.

NAVY

Admiral Mu[illegible]embers who apply and are eligible for PRP or other sensitive programs [illegible]uated in accordance with DOD Directive 5210.42 of April 23, 1981. An extre[illegible] rigorous screening is conducted including security investigation, medical ev[illegible]ation, review of personal files, personal interview, and proficiency qualificat.on. Following this there are continuing evaluations and subsequent screenings. Any involvement in drug abuse immediately disqualifies a member from PRP or other sensitive programs; standards are of the highest calibre. There is constant vigilance maintained throughout these programs to ensure security, professionalism and readiness. Standard law enforcement techniques combined with routine mandatory urinalysis testing programs including random surveys and use of drug detection dogs help to keep personnel assigned to these programs drug free.

AIR FORCE

Answer. A history of pre-service drug use, except limited marihuana experimentation, disqualifies an individual from PRP eligibility. With regard to marihuana experimentation, marihuana use cannot have occurred within six months prior to enlistment. In addition to enlistment drug abuse screening PRP candidates undergo further screening and evaluation during basic military training to help determine their PRP eligibility. After assignment to a PRP position an individual's behavior is thoroughly monitored. Involvement in any incident, whether on- or off-duty, is analyzed for impact on PRP. Any possible involvement in drug or alcohol abuse requires the immediate attention of the individual's commander to determine whether or not to suspend or deny PRP status or a security clearance.

ANTIDRUG MEDIA CAMPAIGN

Senator JEPSEN. Does the DOD plan an anti-drug media campaign? If so, when will it begin and what is the theme of the campaign?

Dr. JOHNS. The Department recently released twelve radio and twelve television alcohol and drug abuse prevention spots through the American Forces Radio and Television Service (AFRTS). We are currently in the process of developing at least thirteen more spots for next year. The spots will focus on four themes: the incompatibility of substance abuse with the military lifestyle, myths and facts about marijuana, new DOD policy on driving while intoxicated, and how to say no to drugs. All of our spots are developed under contract on a competitive bid basis.

We are also using the recently developed NIAAA spots targeted for women and for young men.

DRUG PROBLEM AMONG DOD STUDENTS

Senator JEPSEN. What is the extent of the alcohol and drug abuse problem among students enrolled in DOD schools? Do these students presently receive any education about alcohol and drug abuse? If so, describe.

Dr. JOHNS. While some of our schools have conducted non-scientific prevalence surveys, reliable information on prevalence of alcohol and drug abuse is not yet available. Through an interagency agreement with the National Institute on Drug Abuse, we are including DOD schools in the annual survey of high school seniors for the first time. The data have been collected. We expect a report by late fall and will be happy to forward a copy to you.

Alcohol and drug abuse education in our schools is integrated into the health education curriculum. Students are required to take one semester of health education each year from kindergarten through the twelfth grade.

PARENTS MOVEMENT

Senator JEPSEN. Has DOD made any effort to work with representatives of the Parents Movement?

Dr. JOHNS. I have personally been in contact with several of the nationally prominent leaders of the parents movement. Mr. Otto Moulton for example has provided me with a wealth of literature which he has gathered over a period of years and Mrs. Sue Rusche has participated in one of our DOD Worldwide Drug and Alcohol Abuse conferences. My staff is currently working with Mrs. Joyce Nalepka, NFP, in an effort to learn more about their organizational concepts.

There is much to be learned from the many successes enjoyed by the parents movement and I intend to take full advantage of their experience, dedication, and knowledge.

NATION'S YOUTH DRUG ABUSE

Senator JEPSEN. If alcohol and drug abuse remains at the current level among our Nation's youth, do you really think DOD can significantly reduce substance abuse among military personnel? If so, how can this be done?

Dr. BEARY. Yes we do. We now have the legal tools and will use them along with an intensified education effort. I believe the message that alcohol and drug abuse will not be tolerated is being heard by our troops. We cannot eliminate substance abuse overnight, but we are going to make steady progress in reducing the prevalence of both alcohol and other drug use. There are also some encouraging signs that our society as a whole is becoming less tolerant of alcohol and drug abuse. New initiatives by parents groups against drunk driving and against illicit drug use are gaining momentum and cannot help but aid us in our fight to eliminate substance abuse.

ELIMINATION OF COVERAGE FROM FEDERAL HEALTH BENEFIT PROGRAMS

Senator JEPSEN. There has been a great deal of controversy concerning the elimination of coverage from alcohol and drug treatment from many Federal employees health benefits programs. Has this caused adverse consequences in your overall efforts?

Dr. BEARY. The elimination of coverage for alcoholism from many of the Federal health benefit plans has severely hampered our ability to obtain residential care for our civilian employees. However, we have developed alternative programs for our employees who cannot afford in-patient care. For example, we initiated an after duty hours education program which incorporates as much outpatient care as possible. One goal of this program is to provide alcoholics with additional information concerning the value of treatment and, if it is indicated, convince them that although costs may be high, the risks of not going, may be higher.

Obviously, if our health benefit programs covered alcoholism treatment it would be much easier to convince an individual that he or she needed help. Since most of the plans do not cover alcoholism, we emphasize self-help groups, education etc., but for those people who need residential care and do not have the money we are limited in our ability to assist them with their problem.

Senator HUMPHREY. Thank you very much gentlemen. The hearing is adjourned.

[Whereupon, at 12:28 p.m., the subcommittees adjourned, to reconvene subject to the call of the Chair.]

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